

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

GRAND PARKWAY SURGERY CENTER,
LLC,

Plaintiff,

vs.

HEALTH CARE SERVICE CORPORATION,
A MUTUAL LEGAL RESERVE COMPANY
D/B/A BLUECROSS BLUESHIELD OF
ILLINOIS AND BLUE CROSS BLUE
SHIELD OF TEXAS, INC., A DIVISION OF
HEALTH CARE SERVICE CORPORATION,

Defendant.

Case No. 4:15-cv-00297

Hon. Nancy Atlas

**DEFENDANT HEALTH CARE SERVICE CORPORATION'S MEMORANDUM IN
SUPPORT OF ITS MOTION TO DISMISS PLAINTIFF'S ORIGINAL COMPLAINT**

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Defendant Health Care Service Corporation, a Mutual Legal Reserve Company that does business in Texas as “Blue Cross Blue Shield of Texas” (“HCSC”), by and through its counsel, Foley & Lardner LLP, respectfully moves this Court to dismiss Plaintiff’s Original Complaint (“Complaint”) pursuant to Federal Rules of Civil Procedure 8, 12(b)(1) and 12(b)(6). In support of this Motion, HCSC states as follows:

NATURE OF THE PROCEEDING

Plaintiff filed its Complaint on February 2, 2015, seeking to recover benefits under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. § 1132(a)(1)(B), civil penalties under Section 502(c)(1) of ERISA, 29 U.S.C. § 1132(c)(1), unspecified relief under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), and monetary damages for breach of contract and promissory estoppel. Plaintiff named HCSC¹ as a defendant. Plaintiff purports to sue on behalf of beneficiaries of ERISA and non-ERISA health benefit plans, under purported assignments by the beneficiaries in favor of Plaintiff.

STATEMENT OF ISSUES

- Whether Counts 1 through 4 should be dismissed with prejudice for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) as to the claims for which the applicable plan prohibits assignment of claims by the beneficiary to Plaintiff;

¹ Plaintiff has named “Blue Cross Blue Shield of Texas, Inc.,” as a separate defendant, but that entity merged with HCSC as of December 31, 1998.

- Whether Counts 1 through 4 should be dismissed with prejudice in their entirety pursuant to Rule 12(b)(1) because Plaintiff has insufficiently established its standing to sue as an assignee of the claims alleged;
- Whether Count 1 should be dismissed pursuant to Rule 12(b)(6) for failure to allege specific plan terms that HCSC allegedly breached, which are required elements of a claim under Section 502(a)(1)(B) of ERISA, or to distinguish which claims are included in Count 1 and which are included in Count 4;
- Whether Count 2 should be dismissed with prejudice, as HCSC may not be sued for alleged violations of Section 503 of ERISA, and Plaintiff fails to allege that HCSC is the plan administrator designated by each of the plans at issue such that it may be liable for civil penalties under Section 502(c)(1) of ERISA;
- Whether Count 3 should be dismissed with prejudice because Plaintiff's Section 502(a)(3) claim impermissibly seeks relief that is duplicative of Plaintiff's claims under Sections 502(a)(1)(B) and 502(c)(1) of ERISA;
- Whether Count 4 should be dismissed pursuant to Rule 12(b)(6) because Plaintiff fails to allege the elements of a claim for breach of contract;
- Whether Count 5 should be dismissed pursuant to Rule 12(b)(6) because Plaintiff fails to allege the elements of a claim for promissory estoppel.

STANDARDS OF REVIEW.

Under Rule 8 of the Federal Rules of Civil Procedure, a pleading is required to be "simple, concise and direct" and must give the named defendants fair notice of the plaintiff's claims and the grounds upon which they rest. Fed. R. Civ. P. 8; *Swierkiewicz v. Sorema, N.A.*, 534 U.S. 506, 512 (2002). According to the Supreme Court, in determining the sufficiency of pleadings under Rules 8 and 12(b)(6) of the Federal Rules of Civil Procedure, all conclusory allegations in the complaint must be

disregarded, as they are not entitled to a presumption of truth. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Id.* (internal citations omitted). A claim has "facial plausibility" when the "plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* A complaint, however, will not suffice "if it tenders naked assertions devoid of further factual enhancement." *Id.* (internal citations omitted). A complaint must offer more than "labels and conclusions," and mere "formulaic recitation of the elements of a cause of action" will not do. *Id.*

"A case is properly dismissed for lack of subject matter jurisdiction when the court lacks the statutory or constitutional power to adjudicate the case." *Krim v. pcOrder.com, Inc.*, 402 F.3d 489, 494 (5th Cir. 2005) (citations omitted). In considering a challenge to subject matter jurisdiction, the district court is "free to weigh the evidence and resolve factual disputes in order to satisfy itself that it has the power to hear the case." *Id.* When the court's subject matter jurisdiction is challenged, the party asserting jurisdiction bears the burden of establishing it. *See Castro v. United States*, 560 F.3d 381, 386 (5th Cir. 2009). A motion to dismiss for lack of subject matter jurisdiction should be granted only if it appears certain that the plaintiff cannot prove a plausible set of facts that establish subject matter jurisdiction. *Id.* The Court must "take the well-pled factual allegations of the

complaint as true and view them in the light most favorable to the plaintiff." *Lane v. Halliburton*, 529 F.3d 548, 557 (5th Cir. 2007).

SUMMARY OF THE ARGUMENT

Plaintiff's Complaint should be dismissed with prejudice for a host of reasons, including for lack of standing. The assignment of benefits under which Plaintiff purports to sue is void with respect to many of the claims, as the plan documents out of which those claims arise contain anti-assignment clauses that prohibit assignment of rights and benefits under the Plan. Moreover, Plaintiff has not attached any purported assignments of benefits or otherwise alleged the terms and scope of the purported assignments, as it is required to do in order to establish its standing to sue as an assignee. Plaintiff therefore lacks standing to assert Counts 1 through 4.

Setting aside that Plaintiff lacks standing, Plaintiff also fails to state ERISA claims. Its Section 502(a)(1)(B) claim (Count 1) fails to allege that HCSC breached a specific Plan term or that HCSC controls administration of the Plan such that it may be liable under Section 502(a)(1)(B). Plaintiff also fails to state which claims on Exhibit A to its Complaint are covered by ERISA and which are governed by state law, so that it is impossible to determine to which claims Counts 1 and 4 relate. All of these are required elements of a Section 502(a)(1)(B) claim, and Count 1 (as well as Count 4) should be dismissed for failure to plead them.

Count 2 (alleging failure to provide a full and fair review under Section 503 and seeking civil penalties under Section 502(c)(1)) suffers from a variety of fatal defects. For one, a Section 503 claim may only be asserted against the plan itself, and not against a claims administrator such as BCBSTX. For another, a Section 502(c)(1) claim may only be asserted against the plan administrator designated as such in the plan documents, and Plaintiff does not allege that BCBSTX is designated as plan administrator for each of the plans at issue or that it sent requests for documents to the party designated for such requests in the plan documents. Finally, Plaintiff again fails to distinguish which claims are governed by ERISA and which are not, seeking Section 502(c)(1) penalties with respect to all 293 claims. For all of these defects, Count 2 should be dismissed with prejudice.

Plaintiff's Section 502(a)(3) claim in Count 3 should be dismissed because it impermissibly duplicates Plaintiff's claims under Sections 502(a)(1)(B) and 502(c)(1). In support of its claim for breach of fiduciary duty, Plaintiff alleges only that HCSC denied benefits claims and failed to timely respond to requests for plan documents—ERISA provides specific remedies under Section 502(a)(1)(B) and 502(c)(1) for such allegations, and thus Plaintiff may not state a separate claim under Section 502(a)(3).

Counts 4 and 5 should be dismissed for failing to allege facts sufficient to state a plausible claim for relief. Like Plaintiff's Section 502(a)(1)(B) claim, Plaintiff's breach of contract claim lacks any factual detail regarding the terms of the plans

that HCSC allegedly breached. Similarly, Plaintiff's promissory estoppel claim lacks any factual detail regarding the alleged representations on which Plaintiff allegedly relied. Counts 4 and 5 should be dismissed for these pleading defects.

ARGUMENT

I. Plaintiff Has Not Established Its Standing to Sue as Assignee as to Counts 1 Through 4.

A. The Anti-Assignment Provisions in Many of the ERISA Plans at Issue Prohibit Plaintiff from Suing as an Assignee.

Plaintiff asserts that it is suing based solely on assignments of benefits by the beneficiaries under the various plans. (Doc. 1 at ¶ 16.) As a medical provider, Plaintiff does not have standing to sue HCSC under ERISA without a valid assignment of the rights of a "participant" or "beneficiary," as those terms are defined in Section 502(a) of ERISA. *Tango Transp. v. Healthcare Fin. Serv.*, 322 F.3d 888, 890-91 (5th Cir. 2003) (noting that Section 502(a) only authorizes "a participant or beneficiary" to bring a civil suit). Several of the ERISA-governed plans under which Plaintiff purports to sue prohibit the beneficiary from assigning any rights under the plan, and thus Plaintiff lacks standing to sue as an assignee of rights or benefits under those plans.

While an assignee of a beneficiary's rights to benefits generally may step into the beneficiary's shoes and bring suit under ERISA, the Fifth Circuit has held that anti-assignment provisions in a plan will be upheld. *Letourneau Lifelike Orthotics v. Wal-Mart*, 298 F.3d 348, 352-53 (5th Cir. 2002). *See also Physicians Multispecialty Grp. v. Health Care Plan Horton Homes, Inc.*, 371 F.3d 1291, 1294-96 (11th Cir. 2004)

(“Because ERISA-governed plans are contracts, the parties are free to bargain for certain provisions in the plan—like assignability. Thus, an unambiguous anti-assignment provision in an ERISA-governed welfare benefit plan is valid and enforceable.”); *City of Hope Nat’l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) (“Consistent with the other circuits which have addressed this issue, we hold that ERISA leaves the assignability or non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties.”); *St. Francis Reg’l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1464-65 (10th Cir. 1995) (“ERISA’s silence on the issue of assignability of insurance benefits leaves the matter to the agreement of the contracting parties.”); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991) (“As a general rule of law, where the parties’ intent is clear, courts will enforce non-assignment provisions.”).

Plaintiff does not have valid assignments of the rights or benefits from the beneficiaries under 24 of the ERISA-governed plans at issue. Those plans contain unambiguous anti-assignment clauses that prohibit beneficiaries from assigning any right or benefit to any third party, and therefore Plaintiff lacks standing to sue as an assignee under those 24 plans. Attached as Exhibit A is a spreadsheet showing 33 claims that are included on Exhibit A to the Complaint, which also indicates the plan sponsors for each of the 24 ERISA plans under which those claims arise. Exhibit A

also indicates the page of each plan's benefit booklet that contains anti-assignment language. Most of the benefit booklets contain the following:

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

Others contain the following:

A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person.

Or the following:

You cannot assign your right to receive payment to anyone else, either before or after Covered Services are received.

Copies of the benefit booklets for the 24 ERISA-governed plans described in Exhibit A are collected in Exhibits B through Y.² The Declaration of Jodi Strong, Manager of Contract Administration Operations for Blue Cross and Blue Shield of Texas, is attached as Exhibit Z, which establishes that Exhibits B through Z are true and correct copies of the benefit booklets in effect during the time periods at issue with respect to each of the claims.

² As the Fifth Circuit has noted, "[d]ocuments that a defendant attaches to a motion to dismiss are considered part of the pleadings if they are referred to in the plaintiff's complaint and are central to her claim." *Vanderbrook v. Unitrin Preferred Ins. Co. (In re Katrina Canal Breach Litig.)*, 495 F.3d 191, 205 (5th Cir. 2007) (considering insurance contracts attached to motion to dismiss) (citation omitted). Though the benefits booklets were not attached to the Complaint, they are plan documents that set out the terms of the plans under which Plaintiff purports to sue. They are also referred to in the Complaint. Accordingly, the benefits booklets attached as Exhibit B through O should be considered as part of the pleadings for purposes of HCSC's Motion.

The exact language in the “Assignment and Payment of Benefits” clause that is contained in most of the benefit booklets has been held to prohibit any assignment of participant or beneficiary’s rights and benefits to a medical provider. *See Torpey v. Blue Cross Blue Shield of Texas*, No. 12-cv-7618, 2014 U.S. Dist. LEXIS 11412, *8-9 (D.N.J. Jan. 30, 2014) (finding identical clause was “unambiguous and is enforceable,” and therefore all assignments of benefits were void). “Applying universally recognized canons of contract interpretation to the plain wording of the instant anti-assignment clause leads inexorably to the conclusion that any purported assignment of benefits from [subscribers] to [Plaintiff] would be void.” *Letourneau Lifelike Orthotics*, 298 F.3d at 352. Given that Plaintiff lacks standing to sue as an assignee under the plans listed in Exhibit A, and Counts 1 through 4 are alleged pursuant to purported assignments, Count 1 through 4 should be dismissed with prejudice for lack of subject matter jurisdiction pursuant to Rule 12(b)(1) as to all claims purportedly brought under such plans.

B. Plaintiff Has Not Properly Alleged Its Standing to Sue as an Assignee.

In addition to the fact that many of the plans prohibit assignment of the claims alleged in the Complaint, Plaintiff does not properly allege its standing to sue under assignments of benefits with respect to any of the plans at issue. As a medical provider, Plaintiff does not have standing to sue HCSC under ERISA without a valid assignment of the rights of a “participant” or “beneficiary,” as those terms are defined in Section 502(a) of ERISA. *Tango Transp. v. Healthcare Fin. Serv.*, 322 F.3d

888, 890-91 (5th Cir. 2003) (noting that Section 502(a) only authorizes “a participant or beneficiary” to bring a civil suit). A court only has subject matter jurisdiction to hear ERISA claims brought by a medical provider if the provider has a valid assignment of the claims it seeks to bring. *Romano Woods Dialysis Ctr. v. Admiral Linen Serv., Inc.*, No. H-14-1125, 2014 U.S. Dist. LEXIS 95713, *3-6 (S.D. Tex. July 15, 2014).

The terms and scope of the alleged assignments are especially important since a general assignment of benefits is not sufficient to confer standing on a medical provider to pursue non-benefits claims, such as claims under Section 502(a)(3) or claims for civil penalties under Section 502(c)(1). *Texas Life, Accident & Hosp. Servs. Ins. Guar. Ass’n v. Gaylord*, 105 F.3d 210, 215 (5th Cir. 1997); *Sanctuary Surgical Ctr., Inc. v. Aetna Inc.*, 546 Fed. Appx. 846, 851-52 (11th Cir. 2013).

As the Fifth Circuit has held, the right to sue for breach of fiduciary duty is not a right “provided under the plan,” but rather is “provided by ERISA itself.” *Gaylord*, 105 F.3d at 215. Accordingly, only an “express and knowing assignment of an ERISA fiduciary breach claim is valid.” *Id.* at 218. In fact, a party does not have standing to assert any non-benefits claim in the absence of an express and knowing assignment of such claims. *See Romano Woods Dialysis*, 2014 U.S. Dist. LEXIS 95713, *5-6 (dismissing claims under 29 U.S.C. § 1132(a)(2) and 29 U.S.C. § 1140 because no express assignment of such claims to plaintiff); *Mid-Town Surgical Ctr., L.L.P. v. Humana Health Plan of Tex.*, 16 F. Supp. 3d 767, 775-76 (S.D. Tex. 2014) (dismissing

RICO and fiduciary duty claims where no express assignment of such claims in assignment of benefits).

An assignment must also specifically assign claims for civil penalties to confer standing on a provider to sue under Section 502(c)(1). *See Sanctuary Surgical*, 546 Fed. Appx. at 851-52 (assignee lacked standing to sue under Section 502(c)(1) where beneficiary “assign[ed] only the right to receive benefits and not the right to assert claims for ... civil penalties”); *Tenet Healthcare Ltd. v. Unicare Health Plans of Tex., Inc.*, No. H-07-3534, 2008 U.S. Dist. LEXIS 96324, *19-20 (S.D. Tex. Nov. 26, 2008) (assignment by a beneficiary to a provider of a right to payment does not convert the provider into a “beneficiary” entitled to claim penalties under Section 502(c)(1)).

Plaintiff fails to adequately plead that it has derivative standing to sue through a valid assignment of benefits. Plaintiff does not attach the assignments under which it sues or identify or quote the terms of the assignments, which is required for ERISA benefits by an assignee. *See Franco v. Conn. Gen. Life Ins. Co.*, 818 F. Supp. 2d 792, 811 (D.N.J. 2011) (failure to “plead facts (for example, actual assignment language) to support their legal conclusion that a valid assignment of the proper breadth was given by patients” made the claim deficient). This pleading defect applies equally to Plaintiff’s ERISA benefits claim (Count 1), its other ERISA claims (Counts 2 and 3), and its breach of contract claim (Count 4), which alleges that HCSC breached “the patients’ health benefits plan.” (Doc. 1 at ¶ 54.) Moreover,

Plaintiff's allegation that the beneficiaries assigned their "rights and interest to collect and be reimbursed for the patient's medical service(s)" implies that the alleged assignments were limited to benefits claims and did not specifically assign non-benefits claims such as those contained in Counts 2 and 3. (Doc. 1 at ¶ 16.) Because Plaintiff has failed to properly allege its standing to sue as an assignee of the claims alleged in Counts 1 through 4, the Court should dismiss those counts. *Mid-Town Surgical Ctr.*, 16 F. Supp. 3d at 775-76; *Tenet Healthcare Ltd.*, 2008 U.S. Dist. LEXIS 96324, *19-20. Further, in the event Plaintiff is granted leave to amend its Complaint, the Court should order Plaintiff to produce to HCSC copies of all of the purported assignments so that HCSC and the Court may determine whether Plaintiff has standing to pursue claims on behalf of the beneficiaries.

II. Plaintiff Fails to State a Claim Under Section 502(a)(1)(B) Against HCSC.

Even assuming Plaintiff has standing to assert Count 1, it has not stated a plausible claim for relief under Section 502(a)(1)(B) because it does not identify any specific Plan term that HCSC has breached or identify which claims are those for which it seeks ERISA benefits and which are those for which it seeks remedies under state contract law.

A. Plaintiff Fails to Allege Specific Plan Terms That Were Breached.

The Complaint's failure to identify any specific plan terms that were breached is another pleading defect. *See Innova Hosps. San Antonio, L.P. v. Blue Cross and Blue Shield of Georgia, Inc.*, 995 F. Supp. 2d 587 (N.D. Tex. 2014) ("To state a claim for

benefits under ERISA, a plaintiff must identify a specific plan term that confers the benefit in question.”). Plaintiff does not allege that any specific term of the any of the alleged plans at issue was breached. (*See generally*, Complaint.) Accordingly, Count I should be dismissed for this pleading defect as well. *See Mid-Town Surgical Ctr.*, 16 F. Supp. 3d at 778 (dismissing Section 502(a)(1)(B) claim that only generally referred to “benefits that are due under the terms of the plans”); *Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 902 (S.D. Tex. 2013) (dismissing Section 502(a)(1)(B) claim for failure to “identify a plan term that makes its claims eligible for reimbursement”).

The Complaint alleges only that HCSC “either denied the claims outright or drastically underpaid the claims,” but does not allege a specific plan term that required payment of each denied claim or required that each allegedly underpaid claim be paid at a higher rate. (Doc. 1 at ¶ 17.) These generic allegations are insufficient to provide notice to HCSC of how it is alleged to have breached the terms of each of the plans at issue, and thus Count 1 should be dismissed for failure to state a claim. *Mid-Town Surgical Ctr.*, 16 F. Supp. 3d at 778.

B. Plaintiff Fails to Adequately Identify Which Claims Are At Issue In Counts 1 and 4.

Attached to Plaintiff’s Complaint is a spreadsheet purporting to identify 293 unique claims. (Doc. 1-1.) According to Plaintiff, its “causes of action arise out of violations of two separate categories of insurance policies: ERISA plans and private insurance plans.” (Doc. 1 at ¶ 24.) Plaintiff then alleges two separate causes of action

that each seek to recover same amount of benefits (\$5,728,446.91): Count 1 under Section 502(a)(1)(B) and Count 4 for breach of contract. (*Id.* at ¶¶ 34, 54.) The \$5,728,446.91 of alleged damages for each claim is the total amount of billed charges shown on the spreadsheet minus the total amount that HCSC allegedly paid to Plaintiff. (Doc. 1-1.) Accordingly, Plaintiff does not distinguish which amount it is seeking under Section 502(a)(1)(B) of ERISA with respect to ERISA plans and which it seeks to recover under its breach of contract claim with respect to non-ERISA plans. However, it is required to do so in order to state claims for ERISA benefits and breach of contract. *See Innova Hosp. San Antonio, L.P. v. Blue Cross & Blue Shield of Ga., Inc.*, 995 F. Supp. 2d 587, 601, 604 (N.D. Tex. 2014) (dismissing Section 502(a)(1)(B) and breach of contract claims for insufficient detail).

In *Innova*, the plaintiffs attached a similar spreadsheet to their complaint, which did not identify which of the claims were asserted under ERISA plans and which were asserted under non-ERISA plans. *Id.* at 603-04. The court found the plaintiffs had failed to state a claim for relief because their complaint did not contain sufficient facts about the terms of the ERISA and non-ERISA plans “to allow the Court to reasonably infer that [the defendants] breached these plans.” *Id.* at 601, 604. Similarly, here, the spreadsheet attached to Plaintiff’s Complaint does not differentiate between claims arising from ERISA and non-ERISA plans, and therefore does not state a plausible claim for either ERISA benefits or breach of contract.

III. Plaintiff Does Not State a Claim Under Sections 502(c)(1) or 503.

Count 2 alleges violations of Section 502(c)(1) of ERISA, 29 U.S.C. § 1132(c)(1), which provides for penalties in the event an “administrator” fails to timely provide documents that Section 1024(b)(2) requires a plan to provide upon request by a plan participant or beneficiary. 29 U.S.C. § 1024(b)(2). But it also alleges that HCSC violated Section 503 of ERISA, 29 U.S.C. § 1133, which requires an “employee benefit plan” to provide certain notices regarding denials of claims and to provide opportunities for “full and fair review” of denials, giving rise to a penalty claim under Section 502(c)(1). However, Section 503 and regulations enforcing it (including 29 C.F.R. § 2560.503-1(h)), by their express terms, impose duties only on the “employee benefit plan” and not on plan administrators. *See, e.g., Brown v. J.B. Hunt Transp. Servs.*, 586 F.3d 1079, 1089 (8th Cir. 2009); *Dade v. Sherwin-Williams Co.*, 128 F.3d 1135, 1143 (7th Cir. 1997); *Stuhlreyer v. ARMCO, Inc.*, 12 F.3d 75, 79 (6th Cir. 1993); *Groves v. Modified Retirement Plan*, 803 F.2d 109, 116 (3d Cir. 1986) (all holding that plaintiffs may not seek penalties from plan administrators under Section 506(c)(1) based on violations of Section 503). Plaintiff does not allege that HCSC is the “employee benefit plan” with respect to any of the claims at issue. Accordingly, Plaintiff cannot hold HCSC liable under Section 503, and its request for relief under Section 503 should be dismissed with prejudice.

Understood as a claim for civil penalties under Section 502(c)(1), Count 2 still fails to state a claim. Section 1002(16)(A) of ERISA defines an “administrator” as

“the person specifically so designated by the terms of the instrument under which the plan is operated....” 29 U.S.C. § 1002(16)(A). As a penalty provision, Section 502(c)(1) must be strictly construed. *Kujanek v. Houston Poly Bag I, Ltd.*, 658 F.3d 483, 489 (5th Cir. 2011). As a result, even if a party other than the designated plan administrator was actually responsible for responding to requests for plan documents, only the plan administrator designated by the plan may be sued under Section 502(c)(1). *Averhart v. US West Mgmt. Pension Plan*, 46 F.3d 1480, 1489-90 (10th Cir. 1994); *Jones v. UOP*, 16 F.3d 141, 145 (7th Cir. 1994); *Crowell v. Shell Oil Co.*, 481 F. Supp. 2d 797, 814 (S.D. Tex. 2007); *see also Carson v. Tex. Based Furniture Movers Plan*, No. 3:03-CV-3076-L, 2005 U.S. Dist. LEXIS 17115, *15-16 (N.D. Tex. Aug. 16, 2005) (dismissing Section 502(c)(1) claim alleging that request for documents was sent to entity other than plan administrator); *Mondry v. Am. Family Mut. Ins. Co.*, 557 F.3d 781, 794 (7th Cir. 2009) (request for plan documents sent to claims administrator, and not designated plan administrator, was insufficient to give rise to Section 502(c)(1) claim); *Caffey v. Unum Life Ins. Co.*, 302 F.3d 576, 584-85 (6th Cir. 2002) (request sent to insurance company instead of plan administrator did not support claim for Section 502(c)(1) penalties).

Plaintiff fails to allege that HCSC is the plan administrator designated by each of the plans at issue. Instead, Plaintiff alleges only that HCSC “acted as the plan administrators....” (Doc. 1 at ¶ 25 (emphasis supplied).) This allegation is

insufficient to state a claim for civil penalties under Section 502(c)(1). *Averhart v.*, 46 F.3d at 1489-90; *Jones*, 16 F.3d at 145; *Crowell*, 481 F. Supp. 2d at 814.

Moreover, Plaintiff fails to allege that it sent requests for plan documents to the party designated by each of the plans as the recipient for such requests. Instead, it alleges only that “Plaintiff requested in writing and on multiple occasions, copies of documents related to the claims and plans at issue,” without specifying where and to whom it sent the requests. (Doc. 1 at ¶ 39.) If Plaintiff sent requests for plan documents to someone other than the party designated to receive such requests in each of the plans, it cannot state a claim for penalties under Section 502(c)(1). *Mondry*, 557 F.3d at 794; *Caffey*, 302 F.3d at 584-85.

Finally, Plaintiff does not identify which of the 293 claims in the spreadsheet attached to the Complaint are ERISA claims and which are not. Plaintiff cannot seek damages under Section 502(c)(1) or Section 503 for non-ERISA claims. Plaintiff also fails to identify what HCSC failed to do with respect to any specific ERISA claim, instead alleging a range of possible conduct that may or may not have occurred with respect to a particular claim:

When Plaintiff appealed these determinations, Defendants rarely amended their initial determination that denied or substantially underpaid the benefits owed under the plan. Defendants either provided no explanations for their adverse determinations against Plaintiff or provided conclusory explanations that frequently consisted of one or two sentences that read that Defendants were “maintain[ing] the prior decision” or that the “claim processed correctly.”

(Doc. 1 at ¶ 39 (emphasis supplied).) Plaintiff's intentionally vague style of pleading fails to put HCSC on notice of the alleged conduct serving as the basis for Count 2. For all of these reasons, the Court should dismiss Count 2 with prejudice.

IV. Plaintiff's Section 502(a)(3) Claim Impermissibly Seeks the Same Relief as Its Section 502(a)(1)(B) Claim.

Plaintiff's Section 502(a)(3) claim is barred by Supreme Court and Fifth Circuit authority making clear that, when a party seeks remedies expressly granted by ERISA, the party may not also seek relief under Section 502(a)(3) on the same grounds. *Varity v. Howe*, 516 U.S. 489, 512 (1996) (Section 502(a)(3) is a "'catchall' remedial section" that "act[s] as a safety net, offering appropriate equitable relief for injuries caused by violations that § 502 does not elsewhere adequately remedy."); *LifeCare Mgmt. Servs.*, 703 F.3d at 846 ("When a beneficiary wants what was supposed to have been distributed under a plan, the appropriate remedy is a claim for denial of benefits under § 502(a)(1)(B) of ERISA rather than a ... claim brought pursuant to § 502(a)(3)."); *Rhorer v. Raytheon Eng'rs & Constructors*, 181 F.3d 634, 639 (5th Cir. 1999) ("[B]ecause § 1132(a)(1)(B) affords [plaintiff] an avenue for legal redress, she may not simultaneously maintain her claim for breach of fiduciary duty"; abrogated on other grounds). Accordingly, "an ERISA plaintiff may bring an equitable claim under Section 1132(a)(3) **only** when no other remedy is available under Section 1132." *Gonzales v. Autozone, Inc.*, 776 F. Supp. 2d 405, 409 (S.D. Tex. 2011) (emphasis in original). Moreover, the fact that a plaintiff's Section

502(a)(1)(B) claim fails does not mean the plaintiff can assert a Section 502(a)(3) claim in the alternative. *Tolson v. Avondale Indus.*, 141 F.3d 604, 610 (5th Cir. 1998).

Plaintiff's allegations in Count 3 make clear that its claims are based upon "Defendants' ... failure to follow plan documents" and allegations that HCSC breached alleged fiduciary duties "by not paying or drastically underpaying claims"—in other words, on the same conduct complained of in Count 1. (Doc. 1 at ¶¶ 47, 49.) Moreover, rather than seeking equitable relief under Section 502(a)(3), Plaintiff seeks monetary damages of \$5,728,446.91 (again failing to distinguish which of the underlying claims are ERISA and non-ERISA claims). (*Id.* at ¶ 50.) Because Section 502(a)(1)(B) otherwise provides a remedy for the conduct alleged in Count 3, Plaintiff's claim for equitable relief under Section 502(a)(3) is barred and should be dismissed with prejudice.

V. Plaintiff Fails to Allege a Breach of Contract Claim.

In addition to failing to distinguish which of the claims on its spreadsheet are ERISA and non-ERISA claims, Plaintiff also fails to allege breach of contract for other reasons. Specifically, Plaintiff fails to identify any terms of any plan that HCSC allegedly breached. In order to state a claim for breach of contract, a plaintiff must allege "(1) the existence of a valid contract; (2) performance or tendered performance by the plaintiff; (3) breach of contract by the defendant; and (4) damages suffered by the plaintiff as a result of the breach." *Beauty Mfg. Solutions Corp. v. Ashland, Inc.*, 848 F. Supp. 2d 663, 667 (N.D. Tex. 2012) (citing *Mullins v.*

TestAmerica, Inc., 564 F.3d 386, 418 (5th Cir. 2009); *Aguilar v. Segal*, 167 S.W.3d 443, 450 (Tex. App.—Houston [14th Dist.] 2005, pet. denied)). A breach of contract “only occurs when a party fails or refuses to perform an act that it expressly promised to do.” *Gonzales v. Columbia Hosp. at Med. City Dallas Subsidiary LP*, 207 F. Supp. 2d 570, 575 (N.D. Tex. 2002) (citing *Methodist Hosps. Of Dallas v. Corp. Communicators, Inc.*, 806 S.W.2d 879, 882 (Tex. App.—Dallas 1991, writ denied)). To plead a breach of contract claim, a plaintiff must identify a specific provision of the contract that was allegedly breached. See *Bayway Servs., Inc. v. Ameri-Build Constr., L.C.*, 106 S.W.3d 156, 160 (Tex. App.—Houston [1st Dist.] 2003, no pet.) (“A petition in an action based on a contract must contain a short statement of the cause of action sufficient to give fair notice of the claim involved, including ... the substance of the contract which supports the pleader’s right to recover.”) (internal citations omitted).

In *Innova Hospital*, the court found that a plaintiff failed to state a breach of contract claim where it alleged that the defendants breached the terms of hundreds of benefits plans by paying reimbursements that were “substantially less ... than what [was] actually owed” under the plans. *Innova Hosp.*, 995 F. Supp. 2d at 603. The court found that the claims spreadsheet attached to the complaint did “not identify the non-ERISA contracts” and “contain[ed] no factual allegations regarding what rates were ‘contractually agreed upon’ or ‘required by the contracts.’” *Id.* at 603-04. Accordingly, the plaintiff’s allegations did “not contain enough facts about the terms

of the non-ERISA plans to allow the Court to reasonably infer that [the defendants] breached these plans,” and thus failed to state a claim. *Id.* at 604. *See also Electrostim Med. Servs., Inc. v. Health Care Serv. Corp.*, 962 F. Supp. 2d 887, 902 (S.D. Tex. 2013) (dismissing breach of contract claims where complaint “contain[ed] no factual allegations that the denials were improper or incorrect”); *Motten v. Chase Home Fin.*, 831 F. Supp. 2d 988, 1003-04 (S.D. Tex. 2011) (dismissing breach of contract claim where plaintiff failed to provide contracts that were breached or identify “key terms” that were allegedly breached).

Similarly, here Plaintiff does not identify the specific terms of the plans that HCSC allegedly breached, alleging only that the “plans allow for reimbursement of reasonable and necessary medical expenses at usual and customary rates...” and that it “billed the usual and customary rates for the same or similar medical services rendered and Defendants administered the claims resulting in drastic underpayments in the amount of \$5,728,446.91, inclusive of the ERISA claims, thereby breaching the patients’ health benefits plan.” (Doc. 1 at ¶ 54.) Indeed, given that Plaintiff does not distinguish which of its claims are brought under non-ERISA plans, HCSC cannot even determine which of the claims on Exhibit A to the Complaint are at issue in Count 4. Plaintiff’s allegations simply do not contain enough facts regarding the plans or their terms to raise Plaintiff’s right to relief above the speculative level. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). Accordingly, the Court should dismiss Count 4.

VI. Plaintiff Fails to Allege a Promissory Estoppel Claim.

To state a claim for promissory estoppel, Plaintiff must allege (1) a promise; (2) foreseeability by the promisor that the promisee would rely on the promise; (3) substantial reliance by the promisee to his detriment; and (4) a definite finding that injustice can be avoided only by enforcement of the promise. *Zenor v. El Paso Healthcare Sys. Ltd.*, 176 F.3d 847, 864 (5th Cir. 1999); *G.D. Holdings, Inc. v. H.D.H. Land & Timber, L.P.*, 407 S.W.3d 856, 861 (Tex. App.---Tyler 2013, no pet.). Plaintiff must allege sufficient facts regarding the promises that HCSC allegedly made to Plaintiff. *Innova Hosp.*, 995 F. Supp. 2d at 606-07. In *Innova Hospitals*, the court dismissed similar promissory estoppel claims where the plaintiffs merely recited the elements of promissory estoppel and alleged that the defendants breached promises to pay “by failing to pay and/or underpaying” the plaintiffs’ claims. *Id.* at 606.

Similarly, here Plaintiff alleges only that HCSC verified that services were covered and would be reimbursed at the “usual and customary rate,” and that HCSC “failed to pay and underpaid Plaintiff’s claims.” (Doc. 1 at ¶¶ 58-59.) Such “conclusory allegations” fail to allege sufficient facts to raise Plaintiff’s right to relief above the speculative level, and thus the Court should dismiss Count 5. *Innova Hospital*, 995 F. Supp. 2d at 607.

CONCLUSION

For the reasons set forth above, HCSC respectfully requests that the Court dismiss the Complaint with prejudice.

Dated: April 3, 2015

Respectfully submitted,

/s/Martin J. Bishop

Martin J. Bishop (Tex. Bar No. 24086915)

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on April 3, 2015, a true and correct copy of the foregoing was served via the Court's ECF notice system on all registered ECF filers who have appeared in this action.

/s/ Martin J. Bishop

Exhibit A

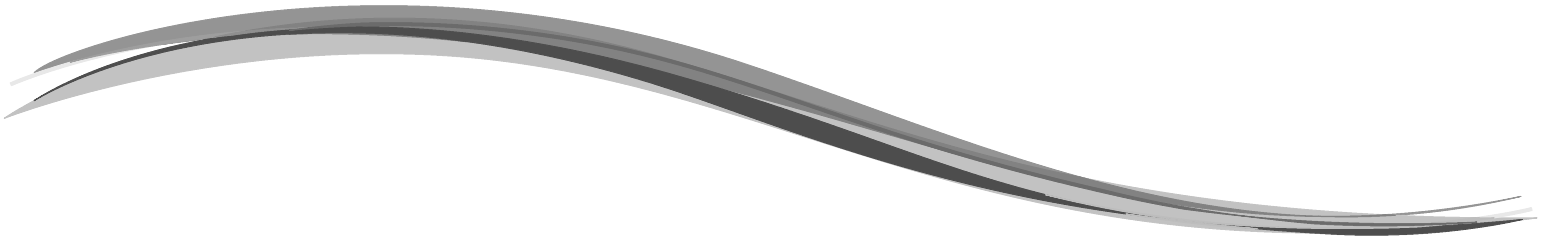
EXHIBIT A

Line No. on Ex. A to Complaint	Group ID Number	Plan Sponsor	Page No. - Anti-Assignment Clause	Ex. No.
18	P19314	National Insurance Crime Bureau	92	S
32	P22308	The McShane Companies	102	X
36	017117	Arthur J. Gallagher & Co.	64	D
42	026987	Permian Mud Service, Inc.	49	U
43	026987	Permian Mud Service, Inc.	49	U
49	YN9876	Kimray, Inc.	52	M
64	P30594	Matrixx Group, Inc.	91	O
89	034407	Patterson-UTI Energy, Inc.	55	T
99	089425	HL Holdings, LLC	63	K
105	044062	Apache Corporation	59	C
122	012812	Club Corp., Inc.	38	H
123	012812	Club Corp., Inc.	38	H
133	018140	BJ Services Co., U.S.A.	55	E
138	097421	Carbo Ceramics, Inc.	49	G
143	055656	Seacor Marine, Inc.	48	W
145	022331	McJunkin Red Man Pipe	59	Q
149	089425	HL Holdings, LLC	63	K
164	073952	Moody International, Inc.	65	P
165	073952	Moody International, Inc.	65	P
176	099187	Rowan Companies	55	V
207	015948	NALCO Companies	98	R
208	YN9744	BOK Financial	54	F
209	YN9744	BOK Financial	54	F
210	YN9744	BOK Financial	54	F
217	972707	Federal Signal Corporation	59	J
218	N13794	Los Alamos National Security, LLC	96	N
219	N13794	Los Alamos National Security, LLC	96	N
221	018140	BJ Services Co., U.S.A.	55	E
250	039865	Weatherford International, Inc.	58	Y
265	044062	Apache Corporation	59	C
266	044062	Apache Corporation	59	C
271	0025010	Acme Brick Co.	49	B
278	029547	Enbridge Employee Services	48	I
284	035852	Kaneka Texas Corporation	57	L

Exhibit A

Exhibit B

Your Health Care Benefit Program



Acme Brick Company

Group #25010 - PPO PREMIUM PLAN

Managed Health Care

Administered by:



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.™

25010AJAN11

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
<ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> 	\$500 – per individual \$1,500 – per family	\$1,000 – per individual \$3,000 – per family
<ul style="list-style-type: none"> Per-Admission Deductible 	\$250 Per-Admission Deductible	\$250 Per-Admission Deductible
Co-Share Stop-Loss Amounts	\$3,000 – per individual	\$6,000 – per individual
Copayment Amounts Required		
<ul style="list-style-type: none"> Physician office visit/consultation – PCP (Family Medicine, OB/GYN, Pediatrician, and Internist) 	\$30 PCP Physician office visit	Does Not Apply
<ul style="list-style-type: none"> Physician office visit/consultation – SCP (all other Specialty Care Providers) 	\$40 SCP Physician office visit	Does Not Apply
<ul style="list-style-type: none"> Outpatient Hospital Emergency Room/Treatment Room visit 	\$150 outpatient Hospital Emergency Room/Treatment Room visit	\$150 outpatient Hospital Emergency Room/Treatment Room visit
<ul style="list-style-type: none"> Urgent Care Center visit 	\$30 PCP Urgent Care Center visit	Does Not Apply
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible \$250 per-admission Deductible	60% of Allowable Amount after Calendar Year Deductible \$250 per-admission Deductible \$250 penalty for failure to preauthorize services
Medical-Surgical Expenses		
<ul style="list-style-type: none"> Office visit/consultation – PCP (Family Medicine, OB/GYN, Pediatrician, and Internist) including lab and x-rays 	100% of Allowable Amount after \$30 PCP Copayment	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Office visit/consultation – SCP (all other Specialty Care Providers), including lab and x-rays 	100% of Allowable Amount after \$40 SCP Copayment	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Independent Lab & X-ray 	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses		
<ul style="list-style-type: none"> Skilled Nursing Facility 	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible
	Calendar Year maximum 25 days per Participant	
<ul style="list-style-type: none"> Home Health Care 	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible
	Calendar Year maximum 60 visits per Participant	
<ul style="list-style-type: none"> Hospice Care 	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible
Emergency Care		
Accident/Medical Emergency		
<ul style="list-style-type: none"> Facility Charges 	80% of Allowable Amount after \$150 outpatient Hospital emergency room Copayment (waived if admitted)	
<ul style="list-style-type: none"> Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care		
<ul style="list-style-type: none"> Facility Charges 	80% of Allowable Amount after Calendar Year Deductible and \$150 outpatient Hospital emergency room Copayment (waived if admitted)	60% of Allowable Amount after Calendar Year Deductible and \$150 outpatient Hospital emergency room Copayment (waived if admitted)
<ul style="list-style-type: none"> Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care		
<ul style="list-style-type: none"> Routine physical examinations Well baby care Routine lab, x-ray, EKG, and diagnostic medical procedures -outpatient or independent setting Preventive Colonoscopies Immunization birth to age 6 Routine x-ray, EKG, and diagnostic medical procedures -office setting Immunizations after 6th birthday vision and hearing exams 	100% of Allowable Amount	Not Covered
	100% of Allowable Amount	100% of Allowable Amount
	100% of Allowable Amount after \$30 PCP/\$40 SCP Copayment	Not Covered
Speech and Hearing Services, excluding hearing aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Urgent Care Urgent Care Center visit – including Lab & x-ray services (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after \$30 PCP Copayment	60% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services <ul style="list-style-type: none"> Physician Expenses (office setting) 	100% of Allowable Amount after \$30 PCP /\$40 SCP Copayment	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Calendar Year maximum 35 visits per Participant	
Behavioral Health Services <ul style="list-style-type: none"> Mental Health Care, Serious Mental Illness and Treatment of Chemical Dependency Preauthorization is required	Benefits will be provided on the same basis as for treatment of any other sickness	Benefits will be provided on the same basis as for treatment of any other sickness
Treatment of Temporomandibular Joint (TMJ) Disorder	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	\$1,000 Lifetime Maximum benefit per Participant	
Morbid Obesity - Bariatric Surgery	Additional \$4,000 Copayment applies. Limited to one surgical procedure per lifetime per Participant Out-of-Network benefits are not available	

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the 12-month period following the Participant's initial Effective Date. This Preexisting Condition waiting period begins on the Effective Date of the Participant's coverage under the Plan, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired). Credit will be given for time served under Creditable Coverage.

Preexisting Conditions for Dependent children under age 19 and all other eligible individuals under age 19 will be covered without any waiting periods.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Services Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care - In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In-Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator – not you – for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co-Share Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care - Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claims Administrator,
- Co-Share and Deductibles,
- Limited or non-covered services, and
- Failure to preauthorize penalty.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-800-521-2227	Monday – Friday 8:00 a.m. – 8:00 p.m.
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Preauthorization Helpline	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m.
Mental Health/Chemical Dependency Preauthorization Helpline	1-800-528-7264	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Physician, Provider of services, or a family member may call the Mental Health Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse;
2. A child under the limiting age shown in your Schedule of Coverage;
3. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
4. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claims Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or

3. Become eligible after the Plan Effective Date and if the application is received by the Claims Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date. If you are a Late Enrollee, you may be subject to a 12-month Preexisting Condition limitation beginning on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
 - c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month following receipt of the application by the Claims Administrator through the Plan Administrator.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Texas Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claims Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period***1. Special Enrollment Period for Newborn Children***

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claims Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claims Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claims Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. Court Ordered Dependent Children

If a court has ordered an Employee to provide coverage for a child, the child and employee will be added to the coverage with the effective date determined by the court order. The Plan Administrator will attempt to gather the enrollment confirmation from the employee, but will proceed with coverage of the child to comply with the court order.

4. Other Dependents

Application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse. If the application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claims Administrator through the Plan Administrator.

Group Enrollment Application/Change Form

Use this form to report any of the following changes to Acme Brick Human Resource Department.

- A change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- All changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

Changes In Your Family

You should promptly notify Acme Brick Human Resource Department in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit a *Group Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.
- When you divorce or your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claims Administrator by the Plan Administrator, refunds will be requested.

Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claims Administrator will pay for Eligible Expenses you incur under the Plan. The Claims Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claims Administrator, you will be responsible for any difference between the Claims Administrator's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claims Administrator.

Case Management

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider <i>(refer to ParPlan, below, for more information)</i>	Out-of-Network Provider <i>(not a contracting Provider)</i>
<ul style="list-style-type: none"> • You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • Your Provider will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claims Administrator's Allowable Amount for covered services • You must preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claims Administrator.
- ***Your group number.*** This is the number assigned to identify your Employer's Health Benefit Plan with the Claims Administrator.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claims Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining other benefits for persons not covered under the Plan;
 - d. Obtaining other benefits that are not covered under the Plan;
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator. Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claims Administrator's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claims Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the 12-month period following the Participant's initial Effective Date of Coverage, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired).

The Preexisting Condition exclusion **will not apply** to:

1. Any individual under age 19; or
2. A newborn child who is added as described in ***Dependent Enrollment Period*** within the first 31 days after the date of birth; or
3. A child who is adopted or involved in a suit for adoption before attaining the limiting age shown in your Schedule of Coverage and who applies, as described in ***Dependent Enrollment Period***, for coverage under this Plan; or
4. A court ordered Dependent of a covered Employee who applies for coverage as described in ***Dependent Enrollment Period***; or
5. An individual who was continuously covered for an aggregate period of twelve months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Health Benefit Plan, excluding any Waiting Periods.

The Claims Administrator will credit the time you were covered under Creditable Coverage if the previous coverage was in effect under a Health Benefit Plan or self-funded Health Benefit Plan at any time during the twelve months prior to the Effective Date of coverage under this Plan. If the previous coverage was issued under a Health Benefit Plan, any waiting period that applied before that coverage became effective also will be credited against the Preexisting Condition exclusion.

Pregnancy, conditions resulting from domestic violence, and genetic information without a diagnosis of a specific condition shall not be considered a Preexisting Condition.

All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Preexisting Condition exclusion is not applicable for the reasons set out above.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.

- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits. Actual availability of benefits is always subject to other requirements of the Plan, such as Preexisting Conditions, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient and outpatient treatment of Chemical Dependency, Mental Health Care and Serious Mental Illness
- If you transfer to another facility or to or from a specialty unit within the facility.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to preauthorize services will require additional steps and/or benefit reductions as described in the section entitled *Failure to Preauthorize*.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification card. After working hours or on weekends, please call the Medical Preauthorization Helpline toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level prior to the visit In-Network Benefits will be paid, otherwise Out-of-Network Benefits will be paid.

When an inpatient Hospital Admission is preauthorized, a length-of-stay is assigned. If you require a longer stay than was first preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section

- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claims Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claims Administrator's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claims Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

All inpatient treatment and outpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized.

To satisfy Preauthorization requirements, you, a family member or your Behavioral Health Practitioner must call the Mental Health/Chemical Dependency Preauthorization Helpline toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The Mental Health/Chemical Dependency Preauthorization Helpline is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level prior to the visit In-Network Benefits will be paid, otherwise Out-of-Network Benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length or service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency as described above, is not obtained:

- BCBSTX will review the Medical Necessity of your treatment prior to the final benefit determination.

- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indication on your Schedule of Coverage
 - Inpatient Hospital Admission
 - Inpatient treatment of Chemical Dependency, Serious Mental Illness or Mental Health Care

The penalty charge will be deducted from any benefit payment which may be due of Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Chemical Dependency, SERIOUS Mental Illness and Mental Health Care or extension for any treatment, service or extension was not Medically Necessary or Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claims Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claims Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled *Participant-filed claims* below for instruction on how to file your own claim forms.

Participant-filed claims

- Medical Claims

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claims Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claims Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claims Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. The Claims Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claims Administrator requires further information in order to process the claim, the Claims Administrator will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by the Claims Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claims Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

If the claim is denied in whole or in part, you will receive a written notice from the Claims Administrator with the following information, if applicable:

- The reasons for denial;
- A reference to the Health Benefit Plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by the Claims Administrator if you do not agree with the denial.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If you believe the Claims Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator's Administrative Office. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Preauthorization Appeal Procedures

If you or your Physician disagree with the determination of the Preauthorization prior to or while receiving services, you may appeal that decision by contacting the Claims Administrator's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Claims Administrator, you may request a review of that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

Once you have requested this review, you may submit additional information and comments on your Preauthorization decision to the Claims Administrator as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your Preauthorization decision held by the Claims Administrator.

Within 30 days of receiving your request to review, the Claims Administrator will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30-day period.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

After exhaustion of all remedies offered by the Claims Administrator, you may exercise your right to appeal all adverse determinations with the Plan Administrator of your Health Benefit Plan. The Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the Health Benefit Plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claims Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or Preauthorization decision upon receipt of a valid written authorization from you or your representative to release the relevant information.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Health Benefit Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under “Copayment Amounts Required” for your specific Plan information.

A Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a family practitioner, a general practitioner, an obstetrician/gynecologist, a pediatrician, an internist or a Professional Other Provider and defined in the **DEFINITIONS** section of this Benefit Booklet. A Copayment Amount is required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

A different Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a Specialty Care Provider as classified by the American Board of Medical Specialties as a Specialty Care Provider.

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense and may be subject to any Deductible shown on your Schedule of Coverage:

- surgery performed in the Physician’s office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for each visit to an Urgent Care Center. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, shown on your Schedule of Coverage:

- surgery performed in the Urgent Care center;
- physical therapy billed separately from an Urgent Care visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an Urgent Care visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Per-admission Deductible: The per-admission Deductible shown under “Deductibles” on your Schedule of Coverage will apply to **each** inpatient Hospital Admission of a Participant.

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

If you have several covered Dependents, all charges used to apply toward an “individual” Deductible amount will be applied toward the “family” Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the “family” Deductible amount.

Eligible Expenses applied toward satisfying the “individual” and “family” Out-of-Network Deductible will apply toward both the Out-of-Network and the In-Network Deductible. However, Eligible Expenses applied toward satisfying the “individual” and “family” In-Network Deductible will not apply toward satisfying the Out-of-Network Deductible.

Co-Share Stop-Loss Amount

Most of your Eligible Expense payment obligations are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss Amount maximum.

Your Co-Share Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
- Any Deductibles;
- Copayment Amounts;
- Penalties applied for failure to preauthorize;

Individual Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the “individual” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to preauthorize that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services.

The benefit percentages of your total eligible Medical-Surgical Expense shown under “Medical-Surgical Expenses” on your Schedule of Coverage in excess of your Copayment Amounts, Co-Share Amounts, and any applicable Deductibles shown are the Plan’s obligation. The remaining unpaid Medical-Surgical Expense in excess of the Copayment Amounts, Co-Share Amounts, and any Deductibles is your obligation to pay.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor, a professional recommendation should be obtained from the Physician.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include:
 - a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
 - b. Home air fluidized bed therapy.

Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

7. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.
19. Elective Abortions.
20. Elective Sterilizations.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the amount of the combined benefit maximums shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Stop-Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
- d. Supplies and equipment routinely provided by the Home Health Agency.

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy;
- Durable medical equipment.

3. For Hospice Care:

Home Hospice Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, speech, and respiratory therapy services by licensed therapists;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your

Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Copayment Amounts, Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Mental Health Care (including Serious Mental Illness and treatment of Chemical Dependency)

Benefits for Eligible Expenses incurred for the treatment of Mental Health Care will be determined on the same basis as for any other treatment of sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Medically Necessary services for Mental Health Care, Serious Mental Illness or treatment of Chemical Dependency in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan as shown on your Schedule of Coverage will apply.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under Benefits for Inpatient Hospital Expense.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care will be determined as shown on your Schedule of Coverage. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived and Preauthorization of the inpatient Hospital Admission will be required.

All treatment received following the onset of an accident injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency and if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room department or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Preventive Care

Benefits for Medical-Surgical Expense are available for the following preventive care services as indicated on your Schedule of Coverage:

- well-baby care (after the newborn's initial examination and discharge from the Hospital);
- routine annual physical examination, including routine lab and x-ray;
- annual vision examination;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***;
- immunizations for Participants age six and over.

Benefits for childhood immunizations will be provided as described in ***Benefits for Childhood Immunizations*** for children under the age of six. Benefits are not available for Inpatient Hospital Expense or Medical-Surgical Expenses for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Mammography Screening

If a Participant incurs Medical-Surgical Expenses for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other Medical-Surgical Expense as shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, Medical-Surgical Expense benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

- a. A postmenopausal woman not receiving estrogen replacement therapy;
- b. An individual with:
 - vertebral abnormalities,
 - primary hyperparathyroidism, or
 - a history of bone fractures; or
- c. An individual who is:
 - receiving long-term glucocorticoid therapy, or
 - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits for Medical-Surgical Expenses incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for services when billed with a medical diagnosis at the applicable Co-Share Amount after the Deductible.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits will be determined on the same basis as for other Medical-Surgical Expenses as shown on your Schedule of Coverage, for each woman enrolled in the Plan who is 18 years of age or older, for Eligible Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer

If a male Participant incurs Medical-Surgical Expenses for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

- a. physical examination for the detection of prostate cancer; and
- b. prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:
 - (1) 50 years of age and asymptomatic; or
 - (2) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Childhood Immunizations

Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co-Share Amounts will not be applicable.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Treatment of Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available for a covered Dependent child from birth but who has not yet reached the age of ten.

Individuals providing treatment prescribed under that plan must be a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder will not apply towards the "Maximum Lifetime Benefits" amount or any other maximum indicated on your Schedule of Coverage.

After the Dependent child reaches the age of ten, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and Preauthorization and benefit maximums.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Services and supplies for reduction mammoplasty when Medically Necessary and in accordance with the medical policy guidelines of the Claims Administrator; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

- a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
 - (1) The transplant procedure is not Experimental/Investigational in nature; and
 - (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
 - (3) The recipient is a Participant under the Plan; and
 - (4) The transplant procedure is preauthorized as required under the Plan; and
 - (5) The Participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and
 - (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

- b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

- (1) A recipient who is covered under this Plan; and
 - (2) A donor who is a Participant under this Plan.
- c. Covered services and supplies include services and supplies provided for the:
- (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
 - (2) Removal of organs or tissues from living or deceased donors; and
 - (3) Transportation and short-term storage of donated organs or tissues.
- d. No benefits are available for a Participant for the following services or supplies:
- (1) Donor search and acceptability testing of potential live donors;
 - (2) Living and/or travel expenses of the recipient or a live donor;
 - (3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
 - (4) Purchase of the organ or tissue; or
 - (5) Organs or tissue (xenograft) obtained from another species.
- e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about Preauthorization.
- (1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
 - (2) At the time of Preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.
- f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claims Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following *services* as a result of and related to an Acquired Brain Injury:

- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior;
- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation - The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

a. *Diabetes Equipment*

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
 - Insulin infusion devices,
 - Batteries,
 - Skin preparation items,
 - Adhesive supplies,
 - Infusion sets,
 - Insulin cartridges,
 - Durable and disposable devices to assist in the injection of insulin, and
 - Other required disposable supplies; and
- (3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

- (1) Test strips specified for use with a corresponding blood glucose monitor,
 - (2) Visual reading and urine test strips and tablets for glucose, ketones, and protein,
 - (3) Lancets and lancet devices,
 - (4) Insulin and insulin analog preparations,
 - (5) Injection aids, including devices used to assist with insulin injection and needleless systems,
 - (6) Biohazard disposable containers,
 - (7) Insulin syringes,
 - (8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
 - (9) Glucagon emergency kits.
- c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
 - d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined

to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

- e. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available and will be determined up to the maximum benefit amount shown on your Schedule of Coverage.

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available as shown on your Schedule of Coverage.

NOTE: A *Calendar Plan Year maximum on medical services, such as routine office visits provided by a chiropractor, will not apply.*

All benefit payments made by the Claims Administrator for Chiropractic Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits, if applicable.

Benefits for Morbid Obesity

Benefits for Medical-Surgical expenses incurred for Morbid Obesity Surgery is available and limited as listed on your Schedule of Coverage. This procedure is subject to the Blue Cross Blue Shield medical guidelines.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
 - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator; or
 - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**

13. Any services or supplies provided for Custodial Care.
14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.
15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
17. Any services or supplies provided for:
 - Treatment of myopia and other errors of refraction, including refractive surgery; or
 - Orthoptics or visual training; or
 - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
 - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the ***Benefits for Preventive Care*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
 - Restoration of loss or correction to an impaired speech or hearing function.
18. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.
19. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.
20. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
21. Any services or supplies provided primarily for:
 - Environmental Sensitivity;
 - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - Inpatient allergy testing or treatment.
22. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
23. Any services or supplies provided for, in preparation for, or in conjunction with:
 - Sterilization reversal (male or female);
 - Transsexual surgery;
 - Sexual dysfunctions;
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear

oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

24. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
25. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
26. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
27. Services or supplies for smoking cessation programs and the treatment of nicotine addiction.
28. Any services or supplies provided for the following treatment modalities:
 - acupuncture;
 - intersegmental traction;
 - surface EMGs;
 - spinal manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
29. Any services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Claims Administrator will be paid at the Out-of-Network benefit level.
30. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.

31. Any benefits in excess of any specified dollar, day/visit or Calendar Year maximum.
32. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
33. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
34. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
35. Private duty nursing services, except for covered Extended Care Expenses.
36. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase other than injectable drugs administered by or under the direct supervision of a Physician or Professional Other Provider.
37. Any non-surgical services or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
38. Any services or supplies provided for the following:
 - Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an

assessment and understanding of the individual's brain-behavioral deficits;

- Cognitive communication therapy - *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Neurocognitive rehabilitation - *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy - *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy - *Services* that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Post-acute transition services - *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration; and
- Community reintegration services - *Services* that facilitate the continuum of care as an affected individual transitions into the community.

39. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with the Claims Administrator in Texas*** – The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claims Administrator. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claims Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claims Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claims Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

- **For procedures, services, or supplies provided to Medicare recipients** - The Allowable Amount will not exceed Medicare's limiting charge.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency, only as listed in this Benefit Booklet.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)
- Ultrasound

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Chiropractic Services means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and

2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claims Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Co-Share Amount means the dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **Co-Share Stop-Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Removal of complete/partial bony impacted teeth;
4. Incision and drainage of facial abscess; and
5. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
 - a. group health insurance coverage;
 - b. individual health insurance coverage; and
 - c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dependent means your spouse or any *child* covered under the Plan who is:

1. Under the Dependent child limiting age shown on your Schedule of Coverage;
2. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered prior to reaching the Dependent limiting age).

Child means:

- a. Your natural child; or
- b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- c. Your stepchild whose primary household is your residence; or
- d. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made; or

- e. A child of your child who is dependent on you for more than one-half of his support as defined by the Internal Revenue Code of the United States; or
- f. A child for whom a Participant has received a court order requiring that Participant to have financial responsibility for providing health insurance; or
- g. A child not listed above:
 - (1) whose primary residence is your household; and
 - (2) to whom you are legal guardian or related by blood or marriage; and
 - (3) who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

- 1. Diet;
- 2. Regulation or management of diet; or
- 3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- 1. placing the patient’s health in serious jeopardy;
- 2. serious impairment of bodily functions;
- 3. serious dysfunction of any bodily organ or part;
- 4. serious disfigurement; or
- 5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who:

- 1. Regularly provides personal services at the Employee’s usual and customary place of employment with the Employer; and
- 2. Works a specified number of hours per week or month as required by the Employer; and
- 3. Is recorded as an Employee on the payroll records of the Employer; and
- 4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means the person, firm, or institution named on this Benefit Booklet.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claims Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claims Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;

5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
 - contain a plan of benefits for employees
 - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
 - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claims Administrator.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claims Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - (1) termination of employment;
 - (2) reduction in the number of hours of employment;
 - (3) termination of the other plan's coverage;
 - (4) termination of contributions toward the premium made by the Employer;
 - (5) COBRA coverage has been exhausted;
 - (6) cessation of Dependent status;
 - (7) the individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
 - (8) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - (9) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
 - d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.

5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
 - a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - c. The child has lost coverage under Medicaid or CHIP; and
 - d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and
2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician or Professional Other Provider; and
3. Billed to the patient by the directing Physician or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, the Hospital, or the Other Provider; and
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claims Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter² or a BMI greater than or equal to 35 kg/meters² with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the 31-day period preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** – an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider

- d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
- a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Optometry
 - e. Doctor of Osteopathy
 - f. Doctor of Podiatry
 - g. Doctor in Psychology
 - h. Licensed Acupuncturist
 - i. Licensed Audiologist
 - j. Licensed Chemical Dependency Counselor
 - k. Licensed Dietitian
 - l. Licensed Hearing Instrument Fitter and Dispenser
 - m. Licensed Marriage and Family Therapist
 - n. Licensed Clinical Social Worker
 - o. Licensed Occupational Therapist
 - p. Licensed Physical Therapist
 - q. Licensed Professional Counselor
 - r. Licensed Speech-Language Pathologist
 - s. Licensed Surgical Assistant
 - t. Nurse First Assistant
 - u. Physician Assistant
 - v. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claims Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 3 months before the earlier of the:

- Effective date of coverage; or
- First day of the Waiting Period.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American

Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)*:

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Pervasive developmental disorders;
7. Schizo-affective disorders (bipolar or depressive); and
8. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claims Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.

Specialty Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a Specialty Care Provider.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claims Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claims Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claims Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claims Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any health care Provider. The Claims Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claims Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claims Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If the Claims Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claims Administrator may deduct any refund due it from any future benefit payment.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
 - a. group or blanket insurance;
 - b. franchise insurance that terminates upon cessation of employment;
 - c. group hospital or medical service plans and other group prepayment coverage;

- d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- e. governmental plans, or coverage required or provided by law.

Plan does not include:

- a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of health insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

- 2. **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- 4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
- 5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- 6. **We or Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

- a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.
- b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

- a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (1) secondary to the Plan covering the Participant as a Dependent and

(2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

(1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

(2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with custody, if applicable;

(3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

- a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claims Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in your Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claims Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan.

Continuation of Group Coverage - Federal

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.
4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information which the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX, as the Claims Administrator is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given the Claims Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

NOTICES

NOTICE

This group health plan believes this plan is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator.

If your group health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTICE
Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blues”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE**CONTINUATION COVERAGE RIGHTS UNDER COBRA**

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of

COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Administered by:



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.SM

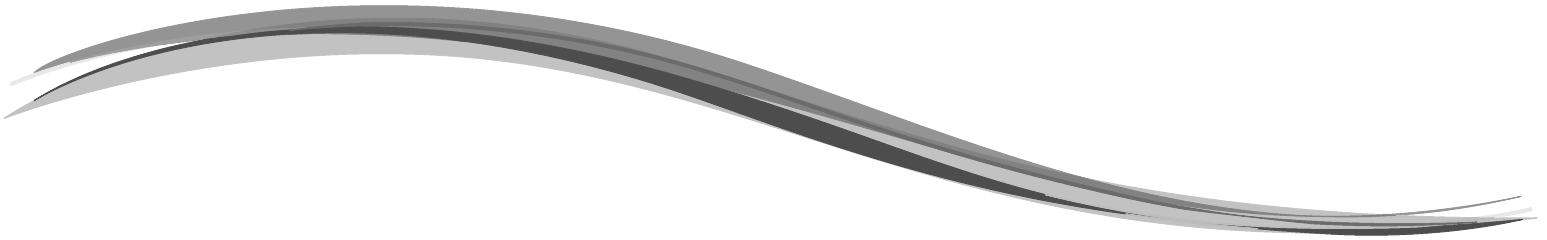
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44111.0108

Exhibit C

Your Health Care Benefit Program



Apache Corporation

Group #44062

PPO Managed Health Care and
Prescription Drug Program

Administered by:



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.™

44062JAN10A

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
<ul style="list-style-type: none"> Calendar Year Deductible 	\$200 – per individual \$400 – per family	\$500 – per individual \$1,000 – per family
Co-Share Stop-Loss Amounts	\$2,000 – per individual \$4,000 – per family	\$5,000 – per individual \$10,000 – per family
Copayment Amounts Required		
<ul style="list-style-type: none"> Physician office visit/consultation 	\$20 Physician office visit	Does Not Apply
<ul style="list-style-type: none"> Urgent Care Center visit 	\$20 Urgent Care Center visit	Does Not Apply
Maximum Lifetime Benefits per Participant	\$3,000,000	
Inpatient Hospital Expenses <i>Preauthorization required</i> All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible \$200 penalty for failure to preauthorize services
Medical-Surgical Expenses		
<ul style="list-style-type: none"> Office visit/consultation/surgery in the office and including lab and x-rays 	100% of Allowable Amount after \$20 Copayment Amount	65% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Certain Diagnostic Procedures 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Inpatient visits 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Home Infusion Therapy <i>Preauthorization required</i> 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Physician surgical services in inpatient or outpatient setting 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Independent Lab & X-ray 	100% of Allowable Amount	100% of Allowable Amount
<ul style="list-style-type: none"> Allergy Injections (without office visit) 	100% of Allowable Amount	65% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses <i>Preauthorization required</i> <ul style="list-style-type: none"> Skilled Nursing Facility 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days combined Calendar Year maximum	
<ul style="list-style-type: none"> Home Health Care 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
	Limited to 60 visits combined Calendar Year maximum	
<ul style="list-style-type: none"> Hospice Care 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
	Limited to \$5,000 each Calendar Year outpatient hospice Limited to \$10,000 combined lifetime maximum	
Mental Health Care Serious Mental Illness Treatment of Chemical Dependency <i>Preauthorization required</i>	Same as any other physical illness	Same as any other physical illness
Emergency Care	<i>Accidental Injury & Emergency Care within first 48 hours</i>	
<ul style="list-style-type: none"> Facility Charges & Physician Charges 	85% of Allowable Amount after Calendar Year Deductible	
	<i>Accidental Injury & Emergency Care after 48 hours</i>	
<ul style="list-style-type: none"> Facility Charges & Physician Charges 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
<ul style="list-style-type: none"> Urgent Care Center visit - including Lab & x-ray services (excluding Certain Diagnostic Procedures) 	100% of Allowable Amount after \$20 Copayment Amount	65% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	85% of Allowable Amount after Calendar Year Deductible	
Preventive Care		
Routine physical examinations, well baby care, immunizations 5 years & over, routine lab and x-ray	100% of Allowable Amount after \$20 Copayment Amount for Physician Office Visit	100% of Allowable Amount up to \$500 per Participant then 65% of Allowable Amount after Calendar Year Deductible
Immunizations birth up to age 5	100% of Allowable Amount	100% of Allowable Amount
Speech and Hearing Services, excluding hearing aids		
<ul style="list-style-type: none"> Office visit and therapy 	100% of Allowable Amount after \$20 Copayment Amount	65% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Other services 	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Chiropractic Services		
• Office visit and other services in the office	100% of Allowable Amount after \$20 Copayment Amount	65% of Allowable Amount after Calendar Year Deductible
• Other services in the outpatient setting	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
	Limited to 10 visits each Calendar Year	
Physical Medicine Services		
• Office visit and other services in the office	100% of Allowable Amount after \$20 Copayment Amount	65% of Allowable Amount after Calendar Year Deductible
• Other services in the outpatient setting	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
Durable Medical Equipment	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible
	Wig limited to 1 each 24-month after cancer treatments or Alopecia Areata	
Organ Transplant	85% of Allowable Amount after Calendar Year Deductible	65% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE
PRESCRIPTION DRUG PROGRAM

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy, Copayment 30-Day Supply	<p style="text-align: center;">Generic Drugs* \$5 Copayment Amount</p> <p style="text-align: center;">Single-source Brand Drugs 25% of Allowable Amount \$15 minimum/\$40 maximum amount</p> <p style="text-align: center;">Multi-source Brand Drugs 25% of Allowable Amount and the cost difference of brand name and generic drugs \$15 minimum/no maximum amount</p> <p style="text-align: center;">Multi-source Brand Drugs non-sedating antihistamines and proton pump inhibitors** 40% Copayment Amount</p>	100% Billed Amount minus Copayment Amount
Retail Pharmacy, Copayment 31-90 Day Supply	<p style="text-align: center;">Generic Drugs* \$10 Copayment Amount</p> <p style="text-align: center;">Single-source Brand Drugs \$50 Copayment Amount</p> <p style="text-align: center;">Multi-source Brand Drugs \$50 Copayment Amount and the cost difference of brand name and generic drugs</p> <p style="text-align: center;">Multi-source Brand Drugs non-sedating antihistamines and proton pump inhibitors** 40% Copayment Amount</p>	100% Billed Amount minus Copayment Amount
Mail Service, Copayment 90-Day Supply	<p style="text-align: center;">Generic Drugs* \$10 Copayment Amount</p> <p style="text-align: center;">Single-source Brand Drugs \$50 Copayment Amount</p> <p style="text-align: center;">Multi-source Brand Drugs \$50 Copayment Amount and the cost difference of brand name and generic drugs</p> <p style="text-align: center;">Multi-source Brand Drugs non-sedating antihistamines and proton pump inhibitors** 40% Copayment Amount</p>	

SCHEDULE OF COVERAGE**PRESCRIPTION DRUG PROGRAM**

Vaccinations obtained through Pharmacies***	No Copayment
Smoking Cessation	Prescription Drugs - no limit Over-The-Counter Products with a written Prescription Order \$500 lifetime maximum
Prior Authorization Provision	Applies
Limitations on Quantities Dispensed	Applies
Diabetes Supplies are available under the Prescription Drug Program portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts, Co-Share Amounts, and any pricing differences.	

* Over-the-counter non-sedating antihistamines and over-the counter proton pump inhibitors are covered under the Generic Drug Copayment Amount with a written Prescription Order.

** If you receive a brand name drug when a generic drug is available, you may incur additional costs. Multi-source Brand Drugs are covered at the Single-source Brand Drug Copayment Amount when the Prescription Order indicated "brand medically necessary". Refer to the Prescription Drug Program portion of this benefit booklet for details.

*** Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 19. Student Age Limit to age 25.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will be limited during the 12-month period following the Participant's initial Effective Date (up to \$2,000 for all conditions combined). This Preexisting Condition waiting period begins on the Effective Date of the Participant's coverage under the Plan, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired). Credit will be given for time served under Creditable Coverage. The Preexisting Condition waiting period is waived on initial enrollment.

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Services Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care - In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In-Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator - not you - for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co-Share Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care - Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claims Administrator,
- Co-Share and Deductibles,
- Limited or non-covered services, and
- Failure to preauthorize penalty.

Prescription Drug Program Benefits

Benefits are provided for those Covered Drugs as explained in the **PRESCRIPTION DRUG PROGRAM** section and shown on your Schedule of Coverage in this Benefit Booklet. The amount of your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy, or at a Non-Participating Pharmacy, or through the Mail Service Prescription Drug Program; or
- a Generic Drug is dispensed; or
- a Single-source Brand Drug or Multi-source Brand Drug is dispensed.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-800-521-2227	Monday – Friday 8:00 a.m. – 8:00 p.m. (CST)
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Preauthorization Helpline	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m. (CST)
Mental Health Helpline	1-800-528-7264	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* and other Providers contracting with BCBSTX
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers
- Assist you with questions regarding the **PRESCRIPTION DRUG PROGRAM**

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health Helpline

To satisfy preauthorization requirements for Participants seeking treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Physician, Provider of services, or a family member may call the Mental Health Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;
2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents are:

1. Your spouse;
2. An unmarried child under the limiting age shown in your Schedule of Coverage;
3. A student under the limiting age shown in your Schedule of Coverage and who is attending an accredited educational institution as a full-time student (as defined by the institution);

Coverage will continue under the Plan for an unmarried Dependent who is unable to maintain full-time student status as a result of a Medically Necessary leave of absence or any other change in enrollment, provided that:

- The Dependent is enrolled under the Plan on the basis of being a student at a postsecondary educational institution; and
- The Dependent was covered immediately before the first day of the Medically Necessary leave of absence or other change in enrollment; and
- The Dependent child's treating Physician provides to the Plan a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is Medically Necessary.

Coverage for such a Dependent may be continued under the Plan until the date that is earlier of:

- One year after the first day of the Medically Necessary leave of absence or other change in enrollment; or
- The date on which such coverage would otherwise terminate under the terms of the Plan

The first day of the Medically Necessary leave of absence will be documented as the date indicated by the Physician in the written certification on which the medical leave or other enrollment change is to begin.

4. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
5. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claims Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or
3. Become eligible after the Plan Effective Date and if the application is received by the Claims Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates - Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan is replacing a discontinued Health Benefit Plan or self-funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self-funded Health Benefit Plan.

Effective Dates - Late Enrollee

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date. If you are a Late Enrollee, you may be subject to a 12-month Preexisting Condition limitation beginning on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or

- c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month following receipt of the application by the Claims Administrator through the Plan Administrator.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or under the Texas Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claims Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. Special Enrollment Period for Newborn Children

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claims Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claims Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claims Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. Court Ordered Dependent Children

If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Employer receives notification of the court order. To continue coverage beyond the 31 days, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period. If you notify the Claims Administrator through the Plan Administrator

after that 31-day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

4. ***Other Dependents***

Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claims Administrator through the Plan Administrator.

2. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the written application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Plan of all changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

You may obtain this form from your Employer, or by calling the Claims Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes In Your Family

You should promptly notify the Claims Administrator through the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit a *Group Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.
- When you divorce, your child marries or reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or "Student Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

Your Schedule of Coverage indicates a "Student Age Limit" for Dependent children who are full-time students on the date they reach the age limit. To continue coverage for that student up to the "Student Age Limit," submit a *Student Dependent Certification Form* within 60 days after the child reaches the "Dependent Child Age Limit." You may obtain this form from your Employer or by calling the Claims Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claims Administrator by the Plan Administrator, refunds will be requested.

Please refer to the **Continuation of Group Coverage - Federal** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claims Administrator will pay for Eligible Expenses you incur under the Plan. The Claims Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claims Administrator, you will be responsible for any difference between the Claims Administrator's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claims Administrator.

Case Management

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider <i>(refer to ParPlan, below, for more information)</i>	Out-of-Network Provider <i>(not a contracting Provider)</i>
<ul style="list-style-type: none"> • You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • Your Provider will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; <i>ParPlan</i> Providers will usually file claims for you • You are not balance billed; <i>ParPlan</i> Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • In most cases, <i>ParPlan</i> Providers will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claims Administrator's Allowable Amount for covered services • You must preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claims Administrator.
- ***Your group number.*** This is the number assigned to identify your Employer's Health Benefit Plan with the Claims Administrator.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers or Participating Pharmacies when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claims Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
 - d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider, or Participating Pharmacy of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of drug purchases and medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator. Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claims Administrator's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claims Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will be limited during the 12-month period following the Participant's initial Effective Date of Coverage, or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired).

The Preexisting Condition exclusion **will not apply** to:

1. A newborn child who is added as described in ***Dependent Enrollment Period*** within the first 31 days after the date of birth; or
2. A child who is adopted or involved in a suit for adoption before attaining the limiting age shown in your Schedule of Coverage and who applies, as described in ***Dependent Enrollment Period***, for coverage under this Plan; or
3. A court ordered Dependent of a covered Employee who applies for coverage as described in ***Dependent Enrollment Period***; or
4. An individual who was continuously covered for an aggregate period of twelve months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Health Benefit Plan, excluding any Waiting Periods.

The Claims Administrator will credit the time you were covered under Creditable Coverage if the previous coverage was in effect under a Health Benefit Plan or self-funded Health Benefit Plan at any time during the twelve months prior to the Effective Date of coverage under this Plan. If the previous coverage was issued under a Health Benefit Plan, any waiting period that applied before that coverage became effective also will be credited against the Preexisting Condition exclusion.

Pregnancy, conditions resulting from domestic violence, and genetic information without a diagnosis of a specific condition shall not be considered a Preexisting Condition.

All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Preexisting Condition exclusion is not applicable for the reasons set out above.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX (a non-contracting Provider), you receive Out-of-Network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Co-Share Amounts.

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity of certain care and services covered under this Plan. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity. However, preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as Preexisting Conditions, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

To satisfy preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Standard Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the “Medical Preauthorization Helpline” toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider’s office. All timelines for preauthorization requirements are provided in keeping with applicable state and federal regulations.

The following types of services require preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient and outpatient treatment of Chemical Dependency,
- All inpatient and outpatient treatment of Mental Health Care,
- All inpatient and outpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will preauthorize services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claims Administrator, and the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for ensuring that preauthorization requirements are satisfied. Failure to preauthorize services will be subject to guidelines described in the paragraph entitled ***Failure to Preauthorize***.

Failure to Preauthorize

If preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency as described above, is not obtained:

- The Claims Administrator will review the Medical Necessity of your treatment prior to the final benefit determination.
- If the Claims Administrator determines the treatment or service is not Medically Necessary, benefits will be reduced or denied; or
- In connection with an inpatient Hospital Admission, you may be responsible for a penalty, if indicated on your Schedule of Coverage. The penalty charge will be deducted from any benefit payment which may be due for the inpatient admission.

- If an inpatient Hospital Admission or extension for any treatment or service described below is not preauthorized and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient Hospital Admission, the call for preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

When an inpatient Hospital Admission is preauthorized, a length-of-stay is assigned. If you require a longer stay than was first preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining preauthorization from BCBSTX.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claims Administrator to request preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claims Administrator's **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

If the Claims Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

All inpatient and outpatient Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency should be preauthorized.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claims Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claims Administrator and some other health care Providers will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled *Participant-filed claims* below for instruction on how to file your own claim forms.

Mail Service Prescription Drug Program

When you receive Covered Drugs dispensed through the Mail Service Prescription Drug Program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Claims Administrator, from the BCBSTX website, or by calling the Customer Service Helpline.

Participant-filed claims

- Medical Claims

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

- Prescription Drug Claims

When you receive Covered Drugs dispensed from a Non-Participating Pharmacy, a *Prescription Reimbursement Claim Form* must be submitted. This form can be obtained from the Claims Administrator or your Employer. This claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

Bills for Covered Drugs should show the name, address and telephone number of the Pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Claim Forms

Medical Claims

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266-0044

Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 14624
Lexington, KY 540512-4624

Mail Service Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Mail Pharmacy
P. O. Box 650041
Dallas, TX 75265-0041

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claims Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claims Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claims Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. The Claims Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claims Administrator requires further information in order to process the claim, the Claims Administrator will request it within that 30-day period.

You have the right to seek and obtain a full and fair review by the Claims Administrator of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claims Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

If the claim is denied in whole or in part, you will receive a written notice from the Claims Administrator with the following information, if applicable:

- The reasons for denial;
- A reference to the Health Benefit Plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by the Claims Administrator if you do not agree with the denial.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If you believe the Claims Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator's Administrative Office. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Preauthorization Appeal Procedures

If you or your Physician disagree with the determination of the preauthorization prior to or while receiving services, you may appeal that decision by contacting the Claims Administrator's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Claims Administrator, you may request a review of that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

Once you have requested this review, you may submit additional information and comments on your preauthorization decision to the Claims Administrator as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your preauthorization decision held by the Claims Administrator.

Within 30 days of receiving your request to review, the Claims Administrator will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30-day period.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

After exhaustion of all remedies offered by the Claims Administrator, you may exercise your right to appeal all adverse determinations with the Plan Administrator of your Health Benefit Plan. The Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the Health Benefit Plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claims Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or preauthorization decision upon receipt of a valid written authorization from you or your representative to release the relevant information.

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Health Benefit Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under “Copayment Amounts Required” for your specific Plan information.

A Copayment Amount will be required for most Physician office visits, including lab and x-ray. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense and may be subject to any Deductible shown on your Schedule of Coverage:

- therapeutic injections;
- any services requiring preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for each visit to an Urgent Care Center. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense, shown on your Schedule of Coverage:

- therapeutic injections;
- any services requiring preauthorization;
- Certain Diagnostic Procedures;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under “Deductibles” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

If you have several covered Dependents, all charges used to apply toward an “individual” Deductible amount will be applied toward the “family” Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the “family” Deductible amount.

Co-Share Stop-Loss Amount

Most of your Eligible Expense payment obligations including Deductibles are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss Amount maximum.

Your Co-Share Stop-Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
- Copayment Amounts;
- Penalties applied for failure to preauthorize;
- Any Copayment Amounts paid under the Prescription Drug Program;
- Any remaining unpaid Medical-Surgical Expense in excess of the benefits provided for Covered Drugs if “Prescription Drug Program” is shown on your Schedule of Coverage.

Individual Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the “individual” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Co-Share Stop-Loss Amount

When the Co-Share Amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the “family” “Co-Share Stop-Loss Amount” shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Co-Share Stop-Loss Amount to the family “Co-Share Stop-Loss Amount.”

The following are exceptions to the Co-Share Stop-Loss Amounts described above:

There are separate Co-Share Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the “individual” Co-Share Stop-Loss Amount maximum will apply toward both the In-Network and the Out-of-Network “Co-Share Stop-Loss Amount” maximum shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the “family” Co-Share Stop-Loss Amount maximum will apply toward both the In-Network and the Out-of-Network “Co-Share Stop-Loss Amount” maximum shown on your Schedule of Coverage.

Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.

Maximum Lifetime Benefits

The total amount of benefits available to any one Participant under the Plan shall not exceed the “Maximum Lifetime Benefits” amount shown on your Schedule of Coverage.

This Maximum Lifetime Benefits amount includes:

1. All payments made by the Claims Administrator under any benefit provisions of the Plan including payments toward any other benefit maximums under the Plan.
2. Any benefits provided to a Participant under a Health Benefit Plan held by the Employer with the Claims Administrator immediately prior to the Participant's Effective Date of coverage under this Plan.
3. All payments made by the Claims Administrator under the Prescription Drug Program portion of this plan.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to preauthorize that may apply to your coverage.

Medical-Surgical Expenses

The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services.

The benefit percentages of your total eligible Medical-Surgical Expense shown under “Medical-Surgical Expenses” on your Schedule of Coverage in excess of your Copayment Amounts, Co-Share Amounts, and any applicable Deductibles shown are the Plan’s obligation. The remaining unpaid Medical-Surgical Expense in excess of the Copayment Amounts, Co-Share Amounts, and any Deductibles is your obligation to pay.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor, a professional recommendation should be obtained from the Physician.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of a certified registered nurse-anesthetist (CRNA).
4. Diagnostic x-ray and laboratory procedures.
5. Radiation therapy.
6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include:
 - a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
 - b. Home air fluidized bed therapy.

Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

7. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services. NOTE: Prescription oral contraceptive medications are covered under the **PRESCRIPTION DRUG PROGRAM** portion of your Plan.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. Foot orthotics.
19. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.
20. Elective abortions.
21. Elective sterilizations for employee and spouse only.
22. Acupuncture.
23. Wigs after Alopecia Areata or cancer treatments, up to the limited amount shown on your Schedule of Coverage.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under “Extended Care Expenses,” and
2. Up to the amount of the combined benefit maximums shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claims Administrator immediately prior to the Participant’s Effective Date of coverage under the Plan.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co-Share Stop-Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:
 - a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
 - b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
 - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
 - a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
 - b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
 - c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
 - d. Supplies and equipment routinely provided by the Home Health Agency.

Benefits will **not** be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy;
- Durable medical equipment.

3. For Hospice Care:

Home Hospice Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, speech, and respiratory therapy services by licensed therapists;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

Facility Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require preauthorization and that any Copayment Amounts, Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for the treatment of Chemical Dependency will be the same as for treatment of any other sickness. Your specific benefits are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Benefits for Inpatient Hospital Expenses**.

Benefits for Treatment of Serious Mental Illness

Benefits for Eligible Expenses incurred for the treatment of Serious Mental Illness are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Medically Necessary services for the treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan as shown on your Schedule of Coverage will apply.

Benefits for Mental Health Care

Benefits for Eligible Expenses incurred for the treatment of Mental Health Care are shown on your Schedule of Coverage. Refer to the **PRAUTHORIZATION REQUIREMENTS** subsection to determine what services require preauthorization.

Medically Necessary services for Mental Health Care in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan as shown on your Schedule of Coverage will apply.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care will be determined as shown on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, preauthorization of the inpatient Hospital Admission will be required.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room department or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Preventive Care

Benefits for Medical-Surgical Expense are available for the following preventive care services as indicated on your Schedule of Coverage:

- well-baby care (after the newborn's initial examination and discharge from the Hospital);
- routine annual physical examination, including routine lab and x-ray;
- immunizations for Participants age five and over.

Benefits for childhood immunizations will be provided as described in ***Benefits for Childhood Immunizations*** for children under the age of five. Benefits are not available for Inpatient Hospital Expense or Medical-Surgical Expenses for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Benefits for preventive care services will be calculated at the benefit percentage shown on your Schedule of Coverage for services listed above up to the maximum benefit amount for Out-of-Network shown under "Preventive Care Benefits." This maximum benefit amount is for the indicated period of time which starts on the first day an Eligible Expense is incurred. After that period of time has elapsed, a new maximum benefit amount begins again. The benefit period and maximum benefit amount are applicable to each Participant individually.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Mammography Screening

If a Participant 35 years of age and older incurs Medical-Surgical Expenses for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other Medical-Surgical Expense as shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, Medical-Surgical Expense benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

- a. A postmenopausal woman not receiving estrogen replacement therapy;
- b. An individual with:
 - vertebral abnormalities,
 - primary hyperparathyroidism, or
 - a history of bone fractures; or
- c. An individual who is:
 - receiving long-term glucocorticoid therapy, or
 - being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits for Medical-Surgical Expenses incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits will be provided for Physician Services under **Preventive Care - Office Visit**, as shown on your Schedule of Coverage.

Benefits will be provided for facilities and anesthesia expenses at the applicable Co-Share Amount after the Deductible.

Benefits will be provided for Physician services when billed with a medical diagnosis at the applicable Co-Share Amount after the Deductible.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits will be determined on the same basis as for other Medical-Surgical Expenses as shown on your Schedule of Coverage, for each woman enrolled in the Plan who is 18 years of age or older, for Eligible Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer

If a male Participant incurs Medical-Surgical Expenses for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

- a. physical examination for the detection of prostate cancer; and
- b. prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:
 - (1) 50 years of age and asymptomatic; or
 - (2) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

Benefits for Childhood Immunizations

Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations from birth through the date the child turns five years of age will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co-Share Amounts will not be applicable.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations

The *Individualized Family Service Plan* must be submitted to the Claims Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered.

Once the child reaches the age of three, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

- a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
 - (1) The transplant procedure is not Experimental/Investigational in nature; and
 - (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
 - (3) The recipient is a Participant under the Plan; and
 - (4) The transplant procedure is preauthorized as required under the Plan; and
 - (5) The Participant meets all of the criteria established by the Claims Administrator in pertinent written medical policies; and

(6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

- b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

Benefits will be available for:

- (1) A recipient who is covered under this Plan; and
- (2) A donor who is a Participant under this Plan.

When both the recipient and donor are covered by the Plan, each participant is entitled to benefits. When the recipient is covered by the Plan, both the donor and recipient are entitled to benefits. The donor’s benefits are limited to benefits not available to the donor from any other benefit source. Another benefit source includes, but is not limited to, any insurance coverage or any government program. Benefits from the donor are charged against the recipient’s coverage under the Plan. When only the donor is covered by the Plan, the donor is entitled to benefits. The benefits are limited to only those not available to the donor from any other source. Another source includes, but is not limited to, any insurance coverage or any governmental program. No benefits are provided to the non-covered transplant recipient. This applies to both a live and cadaver donors.

Benefits for the recipient and the donor will be provided up to the recipient’s “Maximum Lifetime Benefits” amount shown on your Schedule of Coverage. Once the lifetime maximum amount has been exhausted, no further benefits will be available under the Plan.

- c. Covered services and supplies include services and supplies provided for the:

- (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
- (2) Donor search and acceptability testing of potential live donors; and
- (3) Removal of organs or tissues from living or deceased donors; and
- (4) Transportation and short-term storage of donated organs or tissues.

- d. No benefits are available for a Participant for the following services or supplies:

- (5) Living and/or travel expenses of the recipient or a live donor;
- (6) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
- (7) Purchase of the organ or tissue; or
- (8) Organs or tissue (xenograft) obtained from another species.

- e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about preauthorization.

- (1) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization.
- (2) At the time of preauthorization, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

- f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claims Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an Acquired Brain Injury:

- Cognitive communication therapy - *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Cognitive rehabilitation therapy - *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits;
- Community reintegration services - *Services* that facilitate the continuum of care as an affected individual transitions into the community;
- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior;
- Neurocognitive rehabilitation - *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy - *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy - *Services* that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services - *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation - The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

a. Diabetes Equipment

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:

- Insulin infusion devices,
- Batteries,
- Skin preparation items,
- Adhesive supplies,
- Infusion sets,
- Insulin cartridges,
- Durable and disposable devices to assist in the injection of insulin, and
- Other required disposable supplies; and

(3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

- (1) Test strips specified for use with a corresponding blood glucose monitor,
- (2) Visual reading and urine test strips and tablets for glucose, ketones, and protein,
- (3) Lancets and lancet devices,
- (4) Insulin and insulin analog preparations,
- (5) Injection aids, including devices used to assist with insulin injection and needleless systems,
- (6) Biohazard disposable containers,
- (7) Insulin syringes,
- (8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- (9) Glucagon emergency kits.

NOTE: *All Diabetes Supplies listed in item b above will be covered under the Prescription Drug Program portion of your plan.*

- c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
- d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.
- e. Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow-up instruction concerning:

- (1) The physical cause and process of diabetes;
- (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

- (3) Prevention and treatment of special health problems for the diabetic patient;
- (4) Adjustment to lifestyle modifications; and
- (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A *Qualified Participant* means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available and will be determined up to the maximum benefit amount shown on your Schedule of Coverage.

All benefit payments made by the Claims Administrator for Chiropractic Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits.

Benefits for Morbid Obesity

Benefits for Eligible Expenses incurred by a Participant for the Medically Necessary treatment of Morbid Obesity will be provided on the same basis as for any other sickness.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
 - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator; or
 - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or
 - ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**.

13. Any services or supplies provided for Custodial Care.

This exclusion does not apply to the following, as described in **Special Provisions Expenses**:

- preventive care, if shown on your Schedule of Coverage,
- annual mammography screening,
- certain tests for the detection of prostate cancer,
- well-baby check ups,
- detection and prevention of osteoporosis,
- childhood immunizations as provided in this Plan,
- tests for the detection of colorectal cancer.

14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the *Benefits for Dental Services* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the *Benefits for Cosmetic, Reconstructive, or Plastic Surgery* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

17. Any services or supplies provided for:

- Treatment of myopia and other errors of refraction, including refractive surgery; or
- Orthoptics or visual training; or
- Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
- Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the *Benefits for Preventive Care* provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
- Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the *Benefits for Speech and Hearing Services* provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

18. Except as specifically included as an Eligible Expense, any Medical Social Services, any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.

19. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.

20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

21. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.

22. Any services or supplies provided primarily for:

- Environmental Sensitivity;
- Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
- Inpatient allergy testing or treatment.

23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Any services or supplies provided for, in preparation for, or in conjunction with:
 - Sterilization reversal (male or female);
 - Transsexual surgery;
 - Sexual dysfunctions;
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
25. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
26. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Any services or supplies provided for the following treatment modalities:
 - intersegmental traction;
 - surface EMGs;
 - spinal manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
29. Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Claims Administrator will be paid at the Out-of-Network benefit level.
30. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.

31. Any benefits in excess of any specified dollar, day/visit, Calendar Year, or lifetime maximums.
32. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
33. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
34. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
35. Private duty nursing services, except for covered Extended Care Expenses.
36. Any Covered Drugs for which benefits are available under the Prescription Drug Program portion of the Plan.

- 37. Any outpatient prescription or nonprescription drugs.
- 38. Any services or supplies provided for reduction mammoplasty.
- 39. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Allowable Amount means the maximum amount determined by the Claims Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers not contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan outside of Texas*** – The Allowable Amount will be the amount the Claims Administrator would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by the Claims Administrator.
- ***For procedures, services, or supplies provided in Texas by Physicians and Professional Other Providers not contracting with the Claims Administrator*** – The Allowable Amount will be the lesser of the billed charge or the amount the Claims Administrator would have considered for payment for the same covered procedure, service, or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.

If the Claims Administrator does not have sufficient data to calculate the Allowable Amount for a particular procedure, service, or supply, the Claims Administrator will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill, and/or time.

- ***For procedures, services, or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with the Claims Administrator or any other Blue Cross and Blue Shield Plan*** – The Claims Administrator will establish an Allowable Amount using Texas regional or state allowable amounts applicable to procedures, services, or supplies of Physicians or Professional Other Providers with similar skills and experience.
- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount *plus* one-half of the Allowable Amount for each of the other covered procedures performed.
- ***For drugs administered by a Home Infusion Therapy Provider*** – The Allowable Amount will be the lesser of: (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by the Claims Administrator and updated on a periodic basis.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.
- ***For Covered Drugs as applied to Participating and Non-Participating Pharmacies*** – The Allowable Amount for Participating Pharmacies and the Mail Service Prescription Drug Program will be based on the provisions of

the contract between the Claims Administrator and the Participating Pharmacy or Pharmacy for the Mail Service Prescription Drug Program in effect on the date of service. The Allowable Amount for Non-Participating Pharmacies will be based on the Average Wholesale Price.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)
- Ultrasound

Chemical Dependency means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Chiropractic Services means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claims Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non-Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Co-Share Amount means the dollar amount of Eligible Expenses including Deductible(s) incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **Co-Share Stop-Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Incision and drainage of facial abscess; and
4. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
 - a. group health insurance coverage;
 - b. individual health insurance coverage; and
 - c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dependent means your spouse or any unmarried *child* covered under the Plan who is:

1. Under the limiting age shown on your Schedule of Coverage;
2. A student. A "student" is a child under the limiting age shown on your Schedule of Coverage who meets the dependency requirements of the Internal Revenue Code of the United States and who is attending an accredited educational institution as a full-time student as defined by the institution;
3. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered prior to reaching the Dependent limiting age).

Child means:

- a. Your natural child; or
- b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- c. Your stepchild whose primary household is your residence; or
- d. A child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made; or

- e. A child for whom a Participant has received a court order requiring that Participant to have financial responsibility for providing health insurance; or
- f. A child not listed above:
 - (1) whose primary residence is your household; and
 - (2) to whom you are legal guardian or related by blood or marriage; and
 - (3) who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

- 1. Diet;
- 2. Regulation or management of diet; or
- 3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- 1. placing the patient’s health in serious jeopardy;
- 2. serious impairment of bodily functions;
- 3. serious dysfunction of any bodily organ or part;
- 4. serious disfigurement; or
- 5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who:

- 1. Regularly provides personal services at the Employee’s usual and customary place of employment with the Employer; and
- 2. Works a specified number of hours per week or month as required by the Employer; and
- 3. Is recorded as an Employee on the payroll records of the Employer; and
- 4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means the person, firm, or institution named on this Benefit Booklet.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claims Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination.

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claims Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the **Extended Care Expenses** portion of this Benefit Booklet.

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

8. Coverage that provides limited-scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
 - contain a plan of benefits for employees
 - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
 - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the administration of fluids, nutrition, or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or Professional Other Provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Hospice means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which is:

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claims Administrator.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claims Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician or Professional Other Provider; and

2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - (1) termination of employment;
 - (2) reduction in the number of hours of employment;
 - (3) termination of the other plan's coverage;
 - (4) termination of contributions toward the premium made by the Employer;
 - (5) COBRA coverage has been exhausted;
 - (6) cessation of Dependent status;
 - (7) the individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
 - (8) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - (9) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
 - d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.

6. A Dependent child is not a Late Enrollee if the child:
- Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - The child has lost coverage under Medicaid or CHIP; and
 - The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

Medical Social Services means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

- Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and
- Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

- Furnished by or at the direction or prescription of a Physician or Professional Other Provider; and
- Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is:

- Provided by a person employed by the directing Physician or Professional Other Provider; and
- Provided at the usual place of business of the directing Physician or Professional Other Provider; and
- Billed to the patient by the directing Physician or Professional Other Provider.

An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Participant, his Physician, the Hospital, or the Other Provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Claims Administrator shall determine whether a service or supply is Medically Necessary under the Plan and will consider the views of the state and national medical communities, the guidelines and practices

of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Mental Health Care means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter² or a BMI greater than or equal to 35 kg/meters² with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

Network means identified Physicians, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Network Provider means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

Non-Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non-Contracting Facility.

Open Enrollment Period means the 31-day period preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

Other Provider means a person or entity, other than a Hospital or Physician, that is licensed where required to furnish to a Participant an item of service or supply described herein as Eligible Expenses. Other Provider shall include:

1. **Facility Other Provider** - an institution or entity, only as listed:
 - a. Chemical Dependency Treatment Center
 - b. Crisis Stabilization Unit or Facility
 - c. Durable Medical Equipment Provider
 - d. Home Health Agency
 - e. Home Infusion Therapy Provider
 - f. Hospice
 - g. Imaging Center
 - h. Independent Laboratory
 - i. Prosthetics/Orthotics Provider
 - j. Psychiatric Day Treatment Facility
 - k. Renal Dialysis Center
 - l. Residential Treatment Center for Children and Adolescents
 - m. Skilled Nursing Facility
 - n. Therapeutic Center
2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
 - a. Acupuncturist
 - b. Advanced Practice Nurse
 - c. Doctor of Chiropractic
 - d. Doctor of Dentistry
 - e. Doctor of Optometry
 - f. Doctor of Osteopathy
 - g. Doctor of Podiatry
 - h. Doctor in Psychology
 - i. Licensed Acupuncturist
 - j. Licensed Audiologist
 - k. Licensed Chemical Dependency Counselor
 - l. Licensed Dietitian
 - m. Licensed Hearing Instrument Fitter and Dispenser
 - n. Licensed Marriage and Family Therapist
 - o. Licensed Clinical Social Worker
 - p. Licensed Occupational Therapist
 - q. Licensed Physical Therapist
 - r. Licensed Professional Counselor
 - s. Licensed Speech-Language Pathologist
 - t. Licensed Surgical Assistant
 - u. Midwife
 - v. Nurse First Assistant
 - w. Physician Assistant
 - x. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Out-of-Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider.

Out-of-Network Provider means a Hospital, Physician, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

Outpatient Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manual* (Procedure Codes 97010-97799), whether the service or supply is provided by a Physician or Professional Other Provider, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claims Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6 months before the earlier of the:

- Effective date of coverage; or
- First day of the Waiting Period.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

Prosthetics/Orthotics Provider means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

Provider means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)*:

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claims Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

PRESCRIPTION DRUG PROGRAM

This portion of your Plan provides coverage for Medically Necessary Covered Drugs prescribed to treat a Participant for a chronic, disabling, or life-threatening illness covered under the Plan if the drug:

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
 - a. a prescription drug reference compendium, approved by the appropriate state agency, or
 - b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage.

How the Program Works

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy, a Non-Participating Pharmacy, or use the Mail Service Prescription Drug Program. When you need a Specialty Drug Prescription Order filled, you may incur less out-of-pocket expenses by utilizing a BCBSTX Preferred Specialty Drug Provider.

Participating Pharmacy

When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log,
- pay your portion of the Co-Share Amount or/and,
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

Participating Pharmacies have agreed to accept as payment in full the least of:

- the billed charges, or
- the Allowable Amount as determined by the Claims Administrator, or
- other contractually determined payment amounts.

You are responsible for paying any Copayment Amounts or Co-Share Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Non-Participating Pharmacy

If you have a Prescription Order filled or obtain a covered vaccination at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Claims Administrator with itemized receipts verifying that the Prescription Order was filled or a covered vaccination was provided. The Plan will reimburse you for Covered Drugs and covered vaccinations equal to 100% of the billed amount less the appropriate Copayment Amount.

Mail Service Prescription Drug Program

Your Employer has chosen to provide a Mail Service Prescription Program to you and your covered Dependents. The Copayment Amounts are indicated on your Schedule of Coverage.

When you mail your Prescription Orders to the address provided on the *Mail Service Prescription Drug Program Claim Form*, you must send in your payment. If you need assistance in determining the amount of your payment, you may either contact the Customer Service Helpline for assistance or send the amount of payment you determine will be needed.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

If you have any questions about the Program or need to obtain the *Mail Service Prescription Drug Program Claim Form*, you may access our website at www.bcbstx.com or call the Customer Service Helpline at the telephone number shown in this Benefit Booklet or on your Identification Card.

Injectable Drugs

Injectable drugs approved by the FDA are covered under the Plan. You are responsible for any Copayment Amounts or Co-Share Amounts and pricing differences that may apply to the Covered Drug dispensed. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Diabetes Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of Diabetes Supplies for which a Physician or authorized Professional Other Provider has written an order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this Benefit Booklet), shall include but not be limited to the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits

You are responsible for any Copayment Amounts or Co-Share Amounts and any pricing differences that may apply to the items dispensed.

Vaccinations obtained through Participating Pharmacies

Benefits for flu vaccinations, as shown on your Schedule of Coverage, are available through certain Participating Pharmacies that have contracted with BCBSTX to provide this service. To locate one of these contracting Participating Pharmacies in your area, visit the BCBSTX website at www.bcbstx.com or call our Customer Service Helpline number shown in this booklet or on your Identification Card. At the time you receive services, present your BCBSTX identification card to the pharmacist. This will identify you as a Participant in the BCBSTX health care plan provided by your employer. The pharmacist will inform you of the appropriate Copayment Amount, if any, or any Prescription Drug Deductible or Prescription Drug Calendar Year Maximum amount that would apply.

Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Prior Authorizations

To ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require prior authorization and the evaluation of additional clinical information before dispensing for Participants age 25 and older. A list of the medications which require prior authorization is available to you on our website at www.bcbstx.com.

When you present a Prescription Order to a Participating Pharmacy or through the Mail Service Prescription Drug Program or through Preferred Specialty Drug Providers for one of these designated medications, your Physician or authorized Professional Other Provider will be required to submit a *Prior Authorization Request* form on your behalf before the medication can be dispensed.

Non-Participating Pharmacies cannot access the criteria for prior authorizations online. It is important to contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card prior to using one of these Pharmacies since Prescription Orders obtained through a Non-Participating Pharmacy may be denied for reimbursement based upon this criteria.

Limitations on Quantities Dispensed-Day Supply

Benefits for Covered Drugs obtained from a Participating Pharmacy, a Non-Participating Pharmacy, or through the Mail Service Prescription Drug Program or through Preferred Specialty Drug Providers are provided up to the maximum day supply limit indicated on your Schedule of Coverage. The Co-Share Amount or Copayment Amount applicable for the designated day supply of dispensed drugs for retail Pharmacies and the Mail Service Pharmacy and through Preferred Specialty Drug Providers are also indicated on your Schedule of Coverage.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Physician or an authorized Other Professional Provider, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. To determine if a specific drug is subject to this limitation, contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

The day supply of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Physician or authorized Professional Other Provider. The Claims Administrator has the right to determine the day supply at its sole discretion.

Payment for benefits covered under this Plan **may be denied** if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

Participants requiring Prescription Orders in excess of the day supply limit established by the Claims Administrator may ask their Physician or authorized Professional Other Provider to submit a request for clinical review on their behalf. The Physician or authorized Professional Other Provider can obtain the *Quantity Limit Override Request* form by accessing our website at www.bcbstx.com. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information.

Right of Appeal

In the event that a requested Prescription Order is still denied on the basis of prior authorization criteria or a day supply limit after your Physician or authorized Professional Other Provider has submitted clinical documentation, you have the right to appeal as indicated under the **Review of Claim Determinations** section of this Benefit Booklet.

Copayment Amounts

Copayment Amounts

Copayment Amounts for a Participating Pharmacy or a Non-Participating Pharmacy, or the Mail Service Prescription Drug Program or a Preferred Specialty Drug Provider are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed. If the Covered Drug dispensed is a:

1. Generic Drug – You pay the Generic Drug Copayment Amount
2. Single-source Brand Drug – You pay the Single-source Brand Drug Copayment Amount

3. Multi-source Brand Drug – You pay the Multi-source Brand Drug Copayment Amount

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost.

How Copayment Amounts Apply

When your Physician has marked the Prescription Order “Brand Necessary” or “Brand Medically Necessary,” the pharmacist may *only* dispense the brand name drug and you pay the appropriate Single-source Brand Drug Copayment Amount.

If the Physician has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the brand name drug instead of the Generic Drug.

If the brand name drug dispensed is a Multi-source Brand Drug, your payment amount will be the sum of:

- (a) the Single-source Brand Drug Copayment Amount, **plus**
- (b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Multi-source Brand Drug.

Limitations and Exclusions

The benefits of the Prescription Drug Program are not available for:

- 1. Drugs which do not by law require a Prescription Order from a Provider (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and flu vaccinations administered through Pharmacies); and drugs or covered devices for which no valid Prescription Order is obtained.
- 2. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order,) such as, but not limited to therapeutic devices, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies shall be specific exceptions to this exclusion).
- 3. Administration or injection of any drugs.
- 4. Vitamins (**except** Prescription Order prenatal vitamins).
- 5. Drugs dispensed in a Physician’s or authorized Professional Other Provider’s office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- 6. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers’ Compensation law.
- 7. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Flu vaccinations administered through Pharmacies are an exception to this exclusion.
9. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
10. Oral and injectable infertility and fertility medications.
11. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
12. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
13. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Professional Other Provider or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
14. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
15. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
16. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
17. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
18. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
19. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
20. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your Benefit Booklet.
21. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
22. Athletic performance enhancement drugs.
23. Allergy serum and allergy testing materials.
24. Prescription Orders which do not meet the required Prior Authorization criteria.

Definitions

*(In addition to the applicable terms provided in the **DEFINITIONS** Section of the Benefit Booklet, the following terms will apply specifically to this **PRESCRIPTION DRUG PROGRAM** section.)*

Allowable Amount means the maximum amount determined by the Claims Administrator to be eligible for consideration of payment for a particular Covered Drug.

1. As applied to Participating Pharmacies, the Mail Service Prescription Drug Program and Preferred Specialty Drug Providers, the Allowable Amount is based on the provisions of the contract between BCBSTX and the Participating Pharmacy or Pharmacy for the Mail Service Prescription Drug Program or the Preferred Specialty Drug Provider in effect on the date of service.
2. As applied to Non-Participating Pharmacies, the Allowable Amount is based on the Average Wholesale Price.

Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

Compound Drugs means those drugs that meet the following requirements:

1. The drugs in the compounded product are Food and Drug Administration (FDA) approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Prescription Drug Program.

Copayment Amount, with respect to the Prescription Drug Program, means the dollar amount followed by the percentage amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy, Non-Participating Pharmacy or through the Mail Service Prescription Drug Program or through Preferred Specialty Drug Providers.

Co-Share Amount means the dollar amount of Covered Drugs incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by a Physician or authorized Professional Other Provider naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by a Physician or authorized Professional Other Provider;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. For which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Deductible means the dollar amount of Eligible Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Generic Drug means a drug which is approved by the U.S. Food and Drug Administration (FDA) as pharmaceutically and therapeutically equivalent for a particular use or purpose to the Brand Name Drug prescribed.

Generic Drug Copayment Amount means the Copayment Amount applicable if a Generic Drug is dispensed.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

Multi-source Brand Drug means a drug which is available from multiple manufactures. Multi-source Brand Drug refers to drugs that has a generic equivalent drug available.

Multi-source Brand Drug Copayment Amount means the Copayment Amount applicable if a Multi-source Brand Drug is dispensed.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Non-Participating Pharmacy means a retail Pharmacy which has not entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

Participating Pharmacy means an independent retail Pharmacy or chain of retail Pharmacies which have entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Preferred Specialty Drug Providers mean those providers that have entered into an agreement to provide Specialty Drugs under the Prescription Drug Program portion of your Plan.

Prescription Order means a written or verbal order from a Physician or authorized Professional Other Provider to a pharmacist for a drug or device to be dispensed. Orders written by Physicians or authorized Professional Other Providers located outside the United States to be dispensed in the United States are not covered under the Plan.

Single-source Brand Drug means drug can only be purchased from one source, usually the original manufacturer.

Single-source Brand Drug Copayment Amount means the Copayment Amount applicable if a Single-source Brand Drug is dispensed.

Specialty Drugs means those legend drugs that (1) are unique, high-cost medications that may be given by any route of administration, (2) benefit a limited patient population, and (3) typically require complex dispensing technique, delivery procedures, and/or patient education and support.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claims Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between the Employer and the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claims Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claims Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claims Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any health care Provider. The Claims Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claims Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claims Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If the Claims Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claims Administrator may deduct any refund due it from any future benefit payment.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured.
This includes:
 - a. group or blanket insurance;
 - b. franchise insurance that terminates upon cessation of employment;
 - c. group hospital or medical service plans and other group prepayment coverage;

- d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- e. governmental plans, or coverage required or provided by law.

Plan does *not* include:

- a. any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of health insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

- 2. **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

- 4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
- 5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- 6. **We or Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

- a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.
- b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

- a. ***Non-Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (1) secondary to the Plan covering the Participant as a Dependent and

- (2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

- (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
- (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- (1) First, the Plan of the parent with custody of the child;
- (2) Then, the Plan of the spouse of the parent with custody, if applicable;
- (3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

- (1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
- (2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

- a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate on the last day of the month when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claims Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in your Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claims Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan.

Continuation of Group Coverage - Federal

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.
4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information which the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX, as the Claims Administrator is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.
5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given the Claims Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan's provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

NOTICES

NOTICE
Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas (“Host Blues”) may have contracts similar to the contracts described above with certain Providers (“Host Blue Providers”) in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co-Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE**CONTINUATION COVERAGE RIGHTS UNDER COBRA**

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of

COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Administered by:



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.SM

www.bcbstx.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Texas provides administrative services only and does not assume any financial risk or obligation with respect to claims.
44111.0108

Exhibit D

Your Health Care Benefit Program



Arthur J. Gallagher & Co.

Active Medical Plan Group# 017117

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.SM

A message from

Arthur J. Gallagher & Co.

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

Arthur J. Gallagher & Co.

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled “Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers” in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

THE UTILIZATION REVIEW PROGRAM

A special program designed to assist you in determining the course of treatment that will maximize your benefits under this benefit booklet

Lifetime Maximum
for all Benefits

Unlimited

Individual Deductible

- Participating Provider \$700 per benefit period
- Non-Participating and
Non-Administrator Provider \$1,400 per benefit period

Family Deductible

- Participating Provider \$2,100 per benefit period
- Non-Participating and
Non-Administrator Provider \$4,200 per benefit period

Individual Out-of-Pocket
Expense Limit

(does not apply to all services)

- Participating Provider \$4,000 per benefit period
- Non-Participating Provider \$8,000 per benefit period
- Non-Administrator Provider No limit

Family Out-of-Pocket
Expense Limit

- Participating Provider \$12,000 per benefit period
- Non-Participating Provider \$24,000 per benefit period
- Non-Administrator Provider No limit

Physical Therapy Services
Benefit Maximum

30 visits per benefit period

Occupational Therapy
Benefit Maximum

30 visits per benefit period

Speech Therapy
Benefit Maximum

30 visits per benefit period

HOSPITAL BENEFITS

Payment level for Covered
Services from a

Participating Provider:

- Inpatient Covered Services 80% of the Eligible Charge
- Outpatient Covered
Services 80% of the Eligible Charge
- Preventive Care Services 100% of the Eligible Charge
no deductible

Payment level for Covered
Services from a

Non-Participating Provider:

- Inpatient Covered Services 60% of the Eligible Charge
- Outpatient Covered
Services 60% of the Eligible Charge

— Preventive Care Services	60% of the Eligible Charge
Payment level for Covered Services from a Non-Administrator Provider	100% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care	
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider	100% of the Eligible Charge, no deductible
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider	100% of the Eligible Charge, no deductible
Emergency Room	\$100 Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services

- **Participating Provider** 80% of the Maximum Allowance
- **Non-Participating Provider** 60% of the Maximum Allowance

Payment level for
Physician Office Visits

- Participating Provider (other than a specialist) \$25 per visit, then 100% of the Maximum Allowance, no deductible
- Participating Provider Specialist \$35 per visit, then 100% of the Maximum Allowance, no deductible

Payment level for Emergency
Accident Care 100% of the Maximum Allowance,
no deductible

Payment level for Emergency
Medical Care 100% of the Maximum Allowance,
no deductible

Payment level for
Preventive Care Services

- **Participating Provider** 100% of the Maximum Allowance
no deductible
- **Non-Participating Provider** 60% of the Maximum Allowance

Additional Surgical Opinion 100% of the Claim Charge,
no deductible

OTHER COVERED SERVICES

Payment level 80% of the Eligible Charge
or Maximum Allowance

PRESCRIPTION DRUG
PROGRAM BENEFITS

Payment Level

- generic drugs and generic diabetic supplies 80% of the Eligible Charge per prescription (\$7 minimum)
- Formulary brand name drugs and Formulary brand name diabetic supplies 70% of the Eligible Charge per prescription (\$20 minimum)
- non-Formulary brand name drugs and non-Formulary brand name diabetic supplies 60% of the Eligible Charge per prescription (\$35 minimum)
- Copayment for Specialty Drugs 80% of the Eligible Charge per prescription

Home Delivery Prescription
Drug Program

Payment Level

- generic drugs and generic diabetic supplies 80% of the Eligible Charge per prescription (\$14 minimum)
- Formulary brand name drugs and Formulary brand name diabetic supplies 70% of the Eligible Charge per prescription (\$40 minimum)
- non-Formulary brand name drugs and non-Formulary brand name diabetic supplies 60% of the Eligible Charge per prescription (\$70 minimum)

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

ACCIDENT AND ACCIDENTAL.....means an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

AMBULANCE TRANSPORTATION.....means local transportation in a specially equipped certified vehicle from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

An “Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Ambulatory Surgical Facility” means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

AVERAGE DISCOUNT PERCENTAGE (“ADP”).....means a percentage discount determined by the Claim Administrator that will be applied to a Provider’s Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator’s reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding “Claim Administrator’s Separate Financial Arrangements with Providers.”) In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator’s contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness, Serious Mental Illness or Substance Abuse disorders.

BENEFIT PERIOD.....your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following the date.

BIRTHING CENTER.....means any freestanding or Hospital-based facility which provides an "at home" atmosphere for the delivery of babies. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a Registered Nurse (R.N.) or a Licensed Nurse-Midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

CALENDAR YEAR.....means a twelve-month period beginning on the first day of January and ending on the last day of the following December.

CARE MANAGEMENT ORGANIZATION.....is the organization that supplies the services described in the section titled Utilization Review Program.

CERTIFICATE OF CREDITABLE COVERAGE.....means a certificate disclosing information relating to your Creditable Coverage under a health care benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

- (i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and
- (ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A “Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Certified Registered Nurse Anesthetist” means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider’s charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions of this benefit booklet regarding “The Claim Administrator’s Separate Financial Arrangements with Providers.”)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A “Participating Clinical Laboratory” means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Laboratory” means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor.

A “Participating Clinical Professional Counselor” means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Professional Counselor” means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker.

A “Participating Clinical Social Worker” means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Clinical Social Worker” means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes Skilled Nursing Service by a registered professional nurse, the services of physical, occupational and speech therapists, Hospital laboratories, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

- (i) a group health plan.
- (ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.
- (iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).
- (iv) Medicaid (Title XIX of the Social Security Act).
- (v) Medical care for members and certain former members of the uniformed services and their dependents.
- (vi) A medical care program of the Indian Health Service or of a tribal organization.
- (vii) A State health benefits risk pool.
- (viii) A health plan offered under the Federal Employees Health Benefits Program.
- (ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.
- (x) A health plan under Section 5(e) of the Peace Corps Act.
- (xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.). Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.

DENTIST.....means a duly licensed dentist.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

An “Administrator Dialysis Facility” means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Dialysis Facility” means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....as defined in the Arthur J. Gallagher & Co. Domestic Partner Policy

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider.

A “Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Durable Medical Equipment Provider” means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, such Provider’s Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time Covered Services are rendered, will be the lesser of:

- (i) the Provider’s billed charges, or;
- (ii) the Claim Administrator non-contracting Eligible Charge. Except as otherwise provided in this section, the non-contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 400% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Eligible Charge for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Non-Participating or Non-Administrator Providers will be 50% of the Non-Participating or Non-Administrator Provider’s standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE ABUSE ADMISSION.....means an admission for the treatment of Mental Illness or Substance Abuse disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Abuse condition that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

Examples of Mental Illness are: major depression with significant suicidal intent, psychosis with associated homicidal intent or a manic episode resulting in inability to care for oneself.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

ERISA.....is the Employee Retirement Income Security Act of 1974, as amended.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

FOSTER CHILD.....means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom an Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the Employee's; the child depends on the Employee for primary support; the child lives in the home of the Employee; and qualifies as an exemption under the Internal Revenue Code.

A Foster child is not a child temporarily living in the Employee's home; one placed in the Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

GENERIC DRUG.....means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility or special hospice care unit.

HOSPITAL.....means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INITIAL TREATMENT.....means the first medically necessary service received within 48 hours of the onset of an Accidental Injury or Medical Emergency.

INJURY.....means an accident physical Injury to the body caused by unexpected external means.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INVESTIGATIONAL or INVESTIGATIONAL SERVICES AND SUPPLIES.....means procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury or condition.

LEGAL GUARDIAN.....means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

LICENSED PRACTICAL NURSE OR LICENSED VOCATIONAL NURSE.....means an individual who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

LIFETIME.....used in this Plan in the context of benefit maximums and limitations, refers to the "lifetime" of coverage under this Plan, not to the term of an individual's life.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Providers will be based on the Schedule of Maximum Allowances which these Providers have agreed to accept as payment in full. (b) For Non-Participating Professional Providers, the Maximum Allowance will be the lesser of:

- (i) the Provider's billed charges, or;
- (ii) the Claim Administrator non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 400% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

Notwithstanding the preceding sentence, the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Services.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 50% of the Non-Participating Professional Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the Maximum Allowance for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY.....SEE EXCLUSIONS SECTION OF THIS BENEFIT BOOKLET.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL HEALTH UNIT.....means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Mental Illness and Substance Abuse.

MENTAL ILLNESS.....means those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

“Serious Mental Illness”.....means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

- (i) Schizophrenia;
- (ii) Paranoid and other psychotic disorders;
- (iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
- (iv) Major depressive disorders (single episode or recurrent);
- (v) Schizoaffective disorders (bipolar or depressive);
- (vi) Pervasive developmental disorders;
- (vii) Obsessive-compulsive disorders;
- (viii) Depression in childhood and adolescence;
- (ix) Panic disorder;
- (x) Post-traumatic stress disorders (acute, chronic, or with delayed onset); and
- (xi) Anorexia nervosa and bulimia nervosa.

NAPRAPATH.....means a duly licensed naprapath.

NAPRAPATHIC SERVICES.....means the performance of naprapathic practice by a Naprapath which may legally be rendered by them.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist.

A “Participating Optometrist” means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Optometrist” means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider.

A “Participating Orthotic Provider” means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Orthotic Provider” means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Abuse Treatment Facility for the treatment of Mental Illness or Substance Abuse Rehabilitation Treatment in which patients spend days or nights.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means any licensed establishment in which the profession of pharmacy is practiced.

PHYSICAL THERAPIST.....means a duly licensed physical therapist.

PHYSICAL THERAPY.....means the treatment of a disease, injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches.

PHYSICIAN ASSISTANT.....means a duly licensed physician assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider.

PODIATRIST.....means a duly licensed podiatrist.

PREAUTHORIZATION, PREAUTHORIZE or EMERGENCY MENTAL ILLNESS OR SUBSTANCE ABUSE ADMISSION REVIEW.....means a submission of a request to the Mental Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider.

A “Participating Prosthetic Provider” means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Prosthetic Provider” means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you.

An “Administrator Provider” means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Provider” means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A “Participating Provider” means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A “Non-Participating Provider” means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A “Professional Provider” means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A “Participating Prescription Drug Provider” means a Pharmacy that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide services to you at the time you receive the services.

PSYCHOLOGIST.....means a Registered Clinical Psychologist.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois “Psychologists Registration Act” or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant.

A “Participating Registered Surgical Assistant” means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Registered Surgical Assistant” means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision and structure. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for patients with Mental Illness and/or Substance Abuse disorders.

RESPIRE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A “Participating Retail Health Clinic” means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A “Non-Participating Retail Health Clinic” means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

An “Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Skilled Nursing Facility” means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An “Uncertified Skilled Nursing Facility” means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPECIALTY DRUGS.....means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected or infused, but may also include high cost oral medications. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. You should refer to the formulary list, contact your Pharmacy or refer to the Blue Cross and Blue Shield of Illinois Web site (www.bcbsil.com) to determine which drugs are Specialty Drugs.

SPECIALTY PHARMACY PROVIDER.....means a Participating Prescription Drug Provider that has a written agreement with the Claim Administrator or the entity chosen by the Claim Administrator to administer its prescription drug program to provide Specialty Drugs to you at the time you receive the Specialty Drugs.

SPEECH THERAPIST.....means a duly licensed speech therapist.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE ABUSE.....means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Behavioral Health Practitioner.

SUBSTANCE ABUSE REHABILITATION TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Abuse Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE ABUSE TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An “Administrator Substance Abuse Treatment Facility” means a Substance Abuse Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A “Non-Administrator Substance Abuse Treatment Facility” means a Substance Abuse Treatment Facility that does not meet the definition of an Administrator Substance Abuse Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

ELIGIBILITY SECTION

This benefit booklet contains information about the health care benefit program for the persons who:

- Meet the definition of an Eligible Person as determined by your Employer;
- Have applied for this coverage; and
- Have received an identification card.

If you meet this description of an Eligible Person, you are entitled to the benefits of this program.

MEDICARE ELIGIBLE COVERED PERSONS

If you meet the definition of an Eligible Person stated in the ELIGIBILITY Section above and you are eligible for Medicare and not affected by the “Medicare Secondary Payer” (MSP) laws as described below, the benefits described in the section of this benefit booklet entitled “Benefits for Medicare Eligible Covered Persons” will apply to you and to your spouse and covered dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the “Medicare Secondary Payer” (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan (“GHP”) coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

PLEASE NOTE: SEE YOUR EMPLOYER OR GROUP ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.

YOUR MSP RESPONSIBILITIES

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered dependent children. In addition, if you, your spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your group administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

YOUR ID CARD

You will receive an identification card. This card will tell you your identification number and will be very important to you in obtaining your benefits.

INDIVIDUAL COVERAGE

If you have Individual Coverage, only your own expenses for Covered Services are covered, not the expenses of other members of your family.

FAMILY COVERAGE

Child(ren) used hereafter, means a natural child(ren), a stepchild(ren), an adopted child(ren) who is in your custody under an interim court order of adoption or who is placed with you for adoption vesting temporary care.

If you have Family Coverage, your health care expenses and those of your enrolled spouse and your (or your spouse’s) enrolled children who are under age 26 will be covered. The coverage for children will end on the birthday. Spouse means the person to whom the employee is legally married as defined under federal law and through a lawfully solemnized marriage. Specifically

excluded from this definition is any common law marriage which may have been contracted in any state. Moreover, eligibility for any benefit described in this plan is contingent upon satisfactory evidence (such as properly executed marriage license) being submitted to document spousal status.

Your enrolled Domestic Partner and his or her enrolled children who have not attained the limiting age stated above will be covered. Whenever the term “spouse” is used, we also mean Domestic Partner. All of the provisions of this benefit booklet that pertain to a spouse also apply to a Domestic Partner, unless specifically noted otherwise.

Any newborn children will be covered from the moment of birth. Please notify your Group Administrator within 31 days of the date of birth so that your membership records can be adjusted.

Any children who are incapable of self-sustaining employment and are dependent upon you or other care providers for lifetime care and supervision because of a handicapped condition occurring prior to reaching the limiting age will be covered regardless of age if they were covered prior to reaching the limiting age stated above.

Any children who are under your legal guardianship or who are in your custody under an interim court order of adoption or who are placed with you for adoption vesting temporary care will be covered.

This coverage does not include benefits for grandchildren (unless such children are under your legal guardianship).

CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE

You can change from Individual to Family Coverage or add dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Birth, adoption or placement for adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your dependent if:
 - a. The other coverage was in effect when you were first eligible to enroll for this coverage;
 - b. The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
 - c. Where required, you stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- a. Legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, or reduction in the number of hours of employment;
 - b. In the case of HMO, coverage is no longer provided because an individual no longer resides in the service area or the HMO no longer offers coverage in the HMO service area in which the individual resides;
 - c. Reaching a lifetime limit on all benefits in another group health plan;
 - d. Another group health plan no longer offering any benefits to the class of similarly situated individuals that includes you or your dependent;
 - e. When Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
 - f. When you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
- Termination of employer contributions towards your or your dependent’s other coverage.
 - Exhaustion of COBRA continuation coverage or state continuation coverage.

When Coverage Begins

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Domestic Partnership.
- Birth, adoption, or placement of adoption of a child.
- Obtaining legal guardianship of a child.

Your Family Coverage or the coverage for your additional dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your dependent's other coverage.
- Exhaustion of COBRA continuation coverage or state continuation coverage.

If coverage is lost in another group health plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional dependents will be effective from the date your claim was denied.

Your Family Coverage or the coverage for your additional dependents will be effective from the date of the event if you apply for this change within 60 days of any of the following events:

- Loss of eligibility for you or your dependents when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Late Applicants

If you do not apply for Family Coverage or to add dependents within the required number of days of the event, you will have to wait until your Employer's annual open enrollment period to make those changes. Such changes will be effective on a date that has been mutually agreed to by your Employer and the Claim Administrator.

CHANGING FROM FAMILY TO INDIVIDUAL COVERAGE

Should you wish to change from Family to Individual Coverage, you may do this when there is a qualifying family status event. Your Group Administrator will provide you with the application and tell you the date that the change will be effective.

TERMINATION OF COVERAGE

You will no longer be entitled to the benefits described in this benefit booklet if either of the events stated below should occur.

1. If you no longer meet the previously stated description of an Eligible Person.
2. If the entire coverage of your Employer terminates.

Further, termination of the agreement between the Claim Administrator and the Employer automatically terminates your coverage as described in this benefit booklet. It is the responsibility of the Employer to notify you in the event the agreement is terminated with the Claim Administrator. Regardless of whether such notice is provided, your coverage will terminate as of the effective date of termination of the Employer's agreement with the Claim Administrator.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the Health Care Plan described in this benefit booklet except as otherwise specifically stated in the "Extension of Benefits in Case of Termination" provisions of this benefit booklet. However, termination of the Employer agreement with the Claim Administrator and/or termination of your coverage under the Health Care Plan shall not affect any Claim for Covered Services rendered prior to the effective date of such termination.

Unless specifically mentioned elsewhere in this benefit booklet, if one of your dependents becomes ineligible, his or her coverage will end as of the date the event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached).

Other options available for Continuation of Coverage are explained in the COBRA Section of this benefit booklet.

Upon termination of your coverage under the Health Care Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your dependent's coverage under the Health Care Plan.

UTILIZATION REVIEW PROGRAM

The Claim Administrator has established the Utilization Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. The Utilization Review Program requires a review of Inpatient Hospital Covered Services **before** such services are rendered.

You are responsible for satisfying Preadmission/Admission Review requirements. This means that you must ensure that you, your family member, or Provider of services must comply with the guidelines below. Failure to obtain Preadmission/Admission Review for services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO NOTIFY. The toll-free telephone number for Preadmission/Admission Review is on your ID card. Please read the provisions below very carefully.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

Whenever a nonemergency or nonmaternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Health Care Plan.

In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

Upon completion of the preadmission or emergency review, the Claim Administrator will send a letter to your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS - WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as medically necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your identification card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Health Care Service Corporation
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

Should you fail to notify the Claim Administrator as required in the Preadmission Review provision of this section, you will then be responsible for the first \$500 of the Hospital or facility charges for an eligible stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable, as described in this benefit booklet.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT

The Claim Administrator's Mental Health Unit has been established to perform preadmission review and length of stay review for your Inpatient Hospital services for the treatment of Mental Illness and Substance Abuse. The Mental Health Unit is staffed primarily by Physicians, Psychologists, and registered nurses.

Failure to contact the Mental Health Unit or to comply with the determinations of the Mental Health Unit may result in a reduction of benefits. The Mental Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the provision entitled FAILURE TO PREAUTHORIZE OR NOTIFY.

PREAUTHORIZATION REVIEW

- **Inpatient Hospital Preauthorization Review**

Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Abuse by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Abuse Admission Review**

Emergency Mental Illness or Substance Abuse Admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Mental Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Abuse has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

- **Partial Hospitalization Treatment Program Preauthorization Review**

Partial Hospitalization Treatment Program Preauthorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

In order to receive maximum benefits under this Health Care Plan, you must Preauthorize your treatment of Mental Illness or Substance Abuse Rehabilitation Treatment by calling the Mental Health Unit. Participating and Non-Participating Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied. This call must be made at least one day prior to the scheduling of the Partial Hospitalization Treatment Program. The Mental Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Abuse Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Mental Health Unit for an Emergency Mental Illness or Substance Abuse Admission Review.

- **Length of Stay/Service Review**

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan as well as the Preexisting Condition waiting period, if any.

Upon completion of the Preauthorization or Emergency Mental Illness or Substance Abuse Review, the Mental Health Unit will send you a letter confirming that you or your representative called the Mental Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Mental Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Mental Health Unit Physician for review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Mental Health Unit. If the Mental Health Unit Physician concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determination, with a follow-up notification letter sent to you, your Behavioral Health Practitioner and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Mental Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS - WHAT IS NOT COVERED."

The Mental Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Mental Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Mental Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Mental Health Unit Physician decides they were not Medically Necessary.

MENTAL HEALTH UNIT PROCEDURE

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification or your Emergency Mental Illness or Substance Abuse Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Mental Health Unit to Preauthorize your Inpatient Hospital admission, Outpatient service, and /or other service/supply, provide notification of your Emergency Mental Illness or Substance Abuse Admission, or request a length of stay/service review, the Mental Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Mental Health Unit to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Mental Health Unit and requesting an expedited appeal. The Mental Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Mental Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Mental Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Mental Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30 day period, you may review any relevant documents held by the Claim Administrator, if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30 day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Mental Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Mental Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to Preauthorize or notify the Mental Health Unit as required in the Preauthorization Review provision of this section, you will then be responsible for the first \$500 of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

INDIVIDUAL BENEFITS MANAGEMENT PROGRAM ("IBMP")

In addition to the benefits described in this benefit booklet, if your condition would otherwise require continued care in a Hospital or other health care facility, provision of alternative benefits for services rendered by a Participating Provider in accordance with an alternative treatment plan may be available to you.

Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations or exclusions of the Health Care Plan.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S MENTAL HEALTH UNIT section do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois Web site at www.bcbsil.com/ajg for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a \$700 deductible for Covered Services rendered by Participating Provider(s) and a separate \$1,400 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

Expenses incurred by you for Covered Services rendered by a Participating Provider which are applied toward the Participating Provider program deductible will also be applied toward the Non-Participating Provider program deductible.

Expenses incurred by you for Covered Services rendered by a Non-Participating Provider which are applied toward the Non-Participating Provider program deductible will also be applied toward the Participating Provider program deductible.

If you have any expenses for Covered Services during the last three months of a benefit period which were or could have been applied to that benefit period's program deductible, these expenses may be applied toward the program deductible of the next benefit period.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of \$2,100 for Covered Services rendered by Participating Provider(s) and a separate \$4,200 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board and general nursing care when you are in:
 - a semi-private room
 - a private room
 - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an approved Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 40 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient and these services are related to Surgery or Medical Care
7. Emergency Accident Care—treatment must occur within 72 hours of the accident or as soon as reasonably possible.
8. Emergency Medical Care

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services from either a Participating, Non-Participating or Non-Administrator Provider.

Benefits for Emergency Medical Care will not be subject to the program deductible.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of \$100. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary and you must receive such services on or after your Coverage Date.

Remember, whenever the term “you” or “your” is used, we also mean all eligible family members who are covered under Family Coverage.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
2. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
3. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon’s office or Ambulatory Surgical Facility.

In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are elective).

Additional Surgical Opinion

Your coverage includes benefits for an additional surgical opinion following a recommendation for elective Surgery. Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Claim Charge. Your program deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician’s office or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician’s advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not avail-

able for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education and medical nutrition therapy. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered or licensed health care professionals with expertise in diabetes management. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care—Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Occupational Therapy will be limited to a maximum of 30 visits per benefit period.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals. Benefits for Outpatient Physical Therapy will be limited to a maximum of 30 visits per benefit period.

Acupuncture— Benefits will be provided for acupuncture if preformed by a physician.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures.

Radiation Therapy Treatments

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Outpatient Speech Therapy benefits will be limited to a maximum of 30 visits per benefit period.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Mammograms

Pap Smear Test—Benefits will be provided for an annual routine cervical smear or Pap smear test for females.

Human Papillomavirus Vaccine—Benefits will be provided for a human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration. If you purchase the vaccine at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Shingles Vaccine—Benefits will be provided for a shingles vaccine approved by the federal Food and Drug Administration.

Prostate Test and Digital Rectal Examination—Benefits will be provided for an annual routine prostate-specific antigen test and digital rectal examination for males.

Ovarian Cancer Screening—Benefits will be provided for annual ovarian cancer screening for females using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Colorectal Cancer Screening—Benefits will be provided for colorectal cancer screening as prescribed by a Physician, in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Leg, Back, Arm and Neck Braces

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services in a Participating Provider's office (other than a specialist's office), benefits for office visits are subject to a Copayment of \$25 per visit. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services in a Participating Provider specialist's office, benefits for office visits are subject to a Copayment of \$35 per visit. A specialist is a Professional Provider who is **not** a Behavioral Health Practitioner or a Physician in general practice, family practice, internal medicine, psychiatry, obstetrics, gynecology or pediatrics. Benefits for office visits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 60% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

When you receive Covered Services for Emergency Accident Care in a Provider's office (other than a specialist's office), benefits for office visits are subject to a Copayment of \$25 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

When you receive Covered Services for Emergency Accident Care in a Provider's specialist office benefits for office visits are subject to a Copayment of \$35 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

Benefits for Emergency Medical Care will be provided at 100% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider. Your program deductible will not apply.

When you receive Covered Services for Emergency Medical Care in a Provider's office, benefits for office visits are subject to a Copayment of \$25 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

When you receive Covered Services for Emergency Medical Care in a Provider's specialist office benefits for office visits are subject to a Copayment of \$35 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics

- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact Blue Cross Blue Shield at the toll free number provided on your ID card.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes “Other Covered Services” and the benefits that will be provided for them.

- Blood and blood components
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration
- Medical and surgical dressings, supplies, casts and splints
- Naprapathic Service — Benefits will be provided for Naprapathic Services when rendered by a Naprapath.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when you hair loss is due to Chemotherapy.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section. However, benefits for Ambulance Transportation will be provided at 80% of the Claim Charges.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants

- Retail Health Clinics
- Speech Therapists

who have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the particular Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers are:

- Physicians
- Podiatrists
- Psychologists
- Dentists
- Certified Clinical Nurse Specialists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Laboratories
- Clinical Professional Counselors
- Clinical Social Workers
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Physical Therapists
- Prosthetic Providers
- Registered Surgical Assistants
- Retail Health Clinics
- Speech Therapists
- other Professional Providers

who have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact Blue Cross Blue Shield at the toll free number provided on your ID card.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If both the donor and recipient have coverage each will have their benefits paid by their own program.
- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery.
- the evaluation, preparation and delivery of the donor organ.
- the removal of the organ from the donor.
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- **Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs.**
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
- Benefits for transportation and lodging are limited to a combined maximum of \$10,000 per transplant.
- In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:
 - Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
 - Travel time and related expenses required by a Provider.
 - Drugs which do not have approval of the Food and Drug Administration.
 - Storage fees.
 - Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization. Benefits will be limited to a maximum of 36 Outpatient treatment sessions within the six month period.

PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services and will not be subject to any deductible, Coinsurance, Copayment or maximum when such services are received from a Participating Provider:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;
- with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsil.com or contact customer service at the toll-free number on your identification card.

Examples of covered services included are routine annual physicals, immunizations, well child(ren) care, cancer screenings, mammograms, bone density tests, screenings for prostate cancer and colorectal cancer, smoking cessation services and healthy diet counseling and obesity screenings/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, rubella, Tetanus, Varicella and other immunization that is required by law for a child(ren). Allergy injections are not considered immunizations under this benefit provision.

Preventive services received from a Non-Participating Provider or other routine Covered Services not provided for under this provision will be provided at the same payment level as previously described under the Outpatient Hospital Covered Services and Physician Covered Services provision of this benefit booklet.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 60% of the Eligible Charge, once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 90 days of care in a Skilled Nursing Facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 60% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

SUBSTANCE ABUSE REHABILITATION TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Abuse Rehabilitation Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Abuse Treatment Facility, Residential Treatment Facility, day/night treatment and partial hospitalization. Substance Abuse Rehabilitation Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Administrator Provider facility payment level.

MENTAL ILLNESS SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of Mental Illness disorders. Medical Care for the treatment of a Mental Illness is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours).

INFERTILITY TREATMENT

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis of infertility in conjunction with conception through normal intercourse or the inability to sustain a successful pregnancy.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all of the Covered Services previously described in this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge; and
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

PAYMENT PROVISIONS**Lifetime Maximum**

The total dollar amount that will be available in benefits for you is unlimited subject to the separate dollar maximums for specific Covered Services described earlier in this benefit booklet.

Cumulative Benefit Maximums

All benefits payable under this benefit booklet are cumulative. Therefore, in calculating the benefit maximums payable for a particular Covered Service or in calculating the remaining balance under the Lifetime Maximums, the Claim Administrator will include benefit payments under both this and/or any prior or subsequent Claim Administrator's benefit booklet issued to you as an Eligible Person or a dependent of an Eligible Person under this plan.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$4,000, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the program deductible(s)
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- charges for Outpatient prescription drugs
- the Hospital emergency room Copayment
- the Copayment for Physician office visits
- the Copayment for specialist's office visits
- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit
- and any unreimbursed expenses incurred for "comprehensive major medical" covered services within your prior contract's benefit period, if not completed.

If you have Family Coverage and your out-of-pocket expense as described above equals \$12,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Each member and covered dependent may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals \$8,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the program deductible(s)
- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the Utilization Review Program and/or the Claim Administrator's Mental Health Unit

- any unreimbursed expenses incurred for “comprehensive major medical” covered services within your prior contract’s benefit period.

If you have Family Coverage and your expense as described above equals \$24,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Each member and covered dependent may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Partial Hospitalization Treatment Program or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services – Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

OUTPATIENT PRESCRIPTION DRUG PROGRAM BENEFIT SECTION

When you are being treated for an illness or accident, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage includes benefits for drugs and supplies which are self-administered. This section of your benefit booklet explains which drugs and supplies are covered and the benefits that are available for them. Benefits will be provided only if such drugs and supplies are Medically Necessary.

ELIGIBLE CHARGE.....means (a) in the case of a Provider which has a written agreement with a the Claim Administrator or the entity chosen by Blue Cross and Blue Shield to administer its prescription drug program to provide Covered Services to you at the time you receive the Covered Services, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to provide services to you at the time you receive Covered Services, either of the following charges for Covered Services:

- (i) the charge which the particular Prescription Drug Provider usually charges for Covered Services, or
- (ii) the agreed upon cost between Participating Prescription Drug Providers and a Blue Cross and Blue Shield Plan or the entity chosen by the Claim Administrator to administer its prescription drug program, whichever is lower.

Additionally, the following definition(s) shall apply to this Benefit Section:

FORMULARY.....means a brand name drug or brand name diabetic supply that has been designated as a preferred drug or supply by the Claim Administrator.

COVERED SERVICES

The drugs and supplies for which benefits are available under this Benefit Section are:

- drugs which are self-administered that require, by federal law, a written prescription;
- self-injectable insulin and insulin syringes;
- diabetic supplies, as follows: test strips, glucagon emergency kits and lancets.

Benefits for these drugs will be provided when:

- you have been given a written prescription for them by your Physician, Dentist, Optometrist or Podiatrist and
- you purchase the drugs from a Pharmacy or from a Physician, Dentist, Optometrist or Podiatrist who regularly dispenses drugs, and
- the drugs are self-administered.

Benefits will not be provided for:

- drugs used for cosmetic purposes (including, but not limited to, Retin-A/Tretinoin and Minoxidil/Rogaine);
- drugs used for the treatment of infertility;
- drugs for which there is an over-the-counter product available with the same active ingredient(s); other than Omeprazole 20mg;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

One prescription means up to a 34 consecutive day supply of a drug. Certain drugs may be limited to less than a 34 consecutive day supply. However, for certain maintenance type drugs, larger quantities may be obtained through the Home Delivery Prescription Drug Program. For information on these drugs, contact your Participating Prescription Drug Provider or the Claim Administrator's office. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained.

Benefit Payment for Prescription Drugs

The benefits you receive and the amount you pay will differ depending upon the type of drugs purchased and whether they are obtained from a Participating Prescription Drug Provider.

When you obtain drugs and diabetic supplies from a Participating Prescription Drug Provider, benefits will be provided at:

- **80% of the Eligible Charge for each prescription with \$7 minimum**
– for generic drugs and generic diabetic supplies.
- **70% of the Eligible Charge for each prescription with \$20 minimum**
– for Formulary brand name drugs and Formulary brand name diabetic supplies.
- **60% of the Eligible Charge for each prescription with \$40 minimum**
– for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies.

Specialty Drugs from a Participating Prescription Drug Provider

- **80% of the Eligible Charge for each prescription.**

When you obtain drugs or diabetic supplies from a non-Participating Prescription Drug Provider (other than a Participating Prescription Drug Provider), benefits will be provided at 75% of the amount you would have received had you obtained drugs from a Participating Prescription Drug Provider.

Home Delivery Prescription Drug Program

In addition to the benefits described in this Benefit Section, your coverage includes benefits for maintenance type drugs, diabetic supplies and oral contraceptives obtained through the Home Delivery Prescription Drug Program. For information about this program, contact your employer or Claim Administrator.

When you obtain drugs and diabetic supplies through the Home Delivery Prescription Drug Program, benefits will be provided at:

- **80% of the Eligible Charge for each prescription with \$14 minimum**
– for generic drugs and generic diabetic supplies.
- **70% of the Eligible Charge for each prescription with \$40 minimum**
– for Formulary brand name drugs and Formulary brand name diabetic supplies.
- **60% of the Eligible Charge for each prescription with \$80 minimum**
– for non-Formulary brand name drugs and non-Formulary brand name diabetic supplies.

**BENEFITS FOR MEDICARE ELIGIBLE
COVERED PERSONS**

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled “Medicare Eligible Covered Persons” in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage.
2. deduct from the charges eligible under Medicare, the amount paid by Medicare.
3. the lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits (“EOMB”) in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS—WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**

No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or his family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

- Services or supplies that are not specifically mentioned in this benefit booklet.
- Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.
- Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar

Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

- Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.
- Services or supplies that do not meet accepted standards of medical and/or dental practice.
- Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for the cost of routine patient care associated with Investigational cancer treatment, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an approved clinical trial program.
- Custodial Care Service.
- Long Term Care Service.
- Respite Care Service, except as specifically mentioned under the Hospice Care Program.
- Inpatient Private Duty Nursing Service.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
- Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.
- Blood derivatives which are not classified as drugs in the official formularies.
- Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.
- Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of sub-luxations of the foot.
- Routine foot care, except for persons diagnosed with diabetes.
- Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.
- Maintenance Care.
- Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation.
- Hearing aids or examinations for the prescription or fitting of hearing aids, unless otherwise specified in this benefit booklet.
- Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.
- Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.
- Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.
- Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.
- Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.
- Surgical removal of complete bony impacted teeth.

- Elective abortions.
- Reversals of sterilization.
- Premarital or pre-employment examinations.
- Services and supplies rendered or provided for the and treatment of infertility other than in conjunction with conception through normal intercourse; specifically excluded, without limiting this exclusion, are all services and supplies related to artificial insemination and in-vitro fertilization including, but not limited to, gamete intra-fallopian transfer (GIFT).
- Cranial orthotic devices for the treatment of nonsynostotic positional plagiocephaly.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to insure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages. COB does not apply to the Outpatient Prescription Drug Program Benefit Section.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
 - However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
 - when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE RIGHTS UNDER COBRA. See your employer or Group Administrator should you have any questions about COBRA.

Introduction

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with

respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period Of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed Of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

The purpose of this section of your benefit booklet is to explain the options available for temporarily continuing your coverage after termination, if you are covered under this benefit booklet as the Domestic Partner of an Eligible Person or as the dependent child of a Domestic Partner. Your continued coverage under this benefit booklet will be provided only as specified below. Please read the provisions very carefully.

Continuation of Coverage

If you are the Domestic Partner or the dependent child of a Domestic Partner and you lose coverage under this benefit booklet, you have the same options as the spouse or dependent child of an Eligible Person to continue your coverage. The options available to a spouse or a dependent child are described in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable to your Group.

NOTE: Certain employers may not be required to offer COBRA continuation coverage. See your Group Administrator if you have any questions about COBRA.

In addition to the events listed in the CONTINUATION COVERAGE RIGHTS UNDER COBRA section, if applicable, continuation of coverage is available to you and your dependent children in the event you lose coverage because your Domestic Partnership with the Eligible Person terminates. Your Domestic Partnership will terminate if your partnership no longer meets the criteria described in the definition of "Domestic Partnership" in the DEFINITIONS SECTION of this benefit booklet. You are entitled to continue coverage for the same period of time as a spouse or child who loses coverage due to divorce.

CLAIM FILING AND APPEALS PROCEDURES

In order to obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient prescription drugs. This is primarily true when you did not receive an identification card, the Pharmacy was unable to transmit a Claim or you received benefits from a non-Participating Prescription Drug Provider. To do so, follow these instructions:

1. Complete a prescription drug Claim Form. These forms are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.
3. Mail the completed Claim Form with attachments to:

Blue Cross and Blue Shield of Illinois
P.O. Box 14624
Lexington, KY 40512-4624

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

INTERNAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIMS DETERMINATIONS

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.) If you fail to follow the procedures for filing a pre-service claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical claim [as defined below]). Notification may be oral unless the claimant requests written notification.

If a Claim Is Denied or Not Paid in Full

If a claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claim Administrator. A “pre-service claim” is any non-urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
2. For post-service Claims, within 30 days after receipt of the Claim by the Claim Administrator. A “post-service claim” is a Claim as defined above.

If the Claim Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

- a. The reasons for denial;
 - b. A reference to the benefit plan provisions on which the denial is based;
 - c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
 - d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;
 - e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
 - f. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);
 - g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
 - h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
 - i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
 - j. In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as written notice is furnished to the claimant with 3 days of oral notification;
 - k. Contact information for applicable office of health insurance consumer assistance or ombudsman.
3. For benefit determinations relating to urgent care/expedited clinical claim (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.
 4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

An “urgent care/expedited clinical claim” is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

INQUIRIES AND COMPLAINTS

An **“Inquiry”** is a general request for information regarding claims, benefits, or membership.

A **“Complaint”** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with a claim denial (or partial denial), then you have the right to a claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **Customer Service** at the number on the back of your ID card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees or a participating provider.

CLAIM APPEAL PROCEDURES – DEFINITIONS

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer’s benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

In addition, an Adverse Benefit Determination, also includes an “Adverse Determination.” An “**Adverse Determination**” means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this benefit program, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A “**Final Internal Adverse Benefit Determination**” means an Adverse Benefit Determination that has been upheld by the Claim Administrator or your Employer at the completion of the Claim Administrator’s or Employer’s internal review/appeal process.

CLAIM APPEAL PROCEDURES

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator’s (i) coverage determinations that are related to non-urgent care that you have not yet received if approval by your plan is a condition of your opportunity to maximize your benefits and (ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as “appeals.”

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. You may call 1-877-284-9302 or send your request to:

Claim Review Section
 Health Care Service Corporation

P.O. Box 2401
Chicago, Illinois 60690

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or your Employer.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical claim, or health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non-urgent pre-service or post-service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-3333. The Claim Administrator offices are open from 8:45 A.M. to 4:45 P.M., Monday through Friday.

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431, or call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of Claim denials and certain other benefit information may be available in such non-English language(s);

6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the claim and a discussion of the decision.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the INDEPENDENT EXTERNAL REVIEW section below.

If an appeal is not resolved to your satisfaction, you may appeal the Claim Administrator's decision to the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the appeal. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

Some of the operations of the Claim Administrator are regulated by the Illinois Department of Insurance. Filing an appeal does not prevent you from filing a Complaint with the Illinois Department of Insurance or keep the Illinois Department of Insurance from investigating a Complaint.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
 - a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
 - b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
 - c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
 - d. You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we

will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

- 3. Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

- a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
- b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
- c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.
- d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.
- e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
 - (1) Your medical records;
 - (2) The attending health care professional's recommendation;
 - (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;
 - (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
 - (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
 - (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

- (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;
- (6) A statement that judicial review may be available to you or your authorized representative; and
- (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. Request for expedited external review. Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

- a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. Notice of final external review decision. The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within

48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Providers work, please consider the following example:

- a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is \$1,000. How is the \$1,000 bill paid?
- b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.
- c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the \$1,000 Hospital bill would be reduced by 30% to \$700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.
- d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the \$1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of \$700, or \$140. You should note that your 20% Coinsurance is based on the full \$1,000 Hospital bill, after it is reduced by the applicable ADP.
- e. After taking into account the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is \$1,000, your deductible has already been satisfied, and your Coinsurance is \$140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or \$860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the \$860 bill that remains after your Coinsurance and deductible, by paying less than \$860 to the Hospital, often substantially less than \$860. The Claim Administrator receives, and keeps for its own account, the difference between the \$860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

Other Blue Cross and Blue Shields' Separate Financial Arrangements with Providers

Blue Card

The Claim Administrator hereby informs you that other Blue Cross and Blue Shield Plans outside of Illinois ("Host Blue") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service area.

When you receive health care services through BlueCard outside of Illinois and from a Provider which does not have a contract with the Claim Administrator, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or

- The negotiated price that the Host Blue passes on to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

- Suppose you receive covered medical services for an illness while you are on vacation outside of Illinois. You show your identification card to the provider to let him or her know that you are covered by the Claim Administrator.
- The provider has negotiated with the Host Blue a price of \$80, even though the provider's standard charge for this service is \$100. In this example, the provider bills the Host Blue \$100.
- The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is \$80. The Claim Administrator would then base the amount you must pay for the service – the amount applied to your deductible, if any, and your coinsurance percentage – on the \$80 negotiated price, not the \$100 billed charge.
- So, for example, if your coinsurance is 20%, you would pay \$16 (20% of \$80), not \$20 (20% of \$100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that factors into the actual price increases or reductions to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, the Claim Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (“Servicing Plans”) to provide, on the Claim Administrator’s behalf, Claim Payments and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator’s behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers (“Servicing Plan Providers”) in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan’s applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider’s Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state’s statutory method.

Claim Administrator’s Separate Financial Arrangements with Prescription Drug Providers

The Claim Administrator hereby informs you that it has contracts, either directly or indirectly, with Prescription Drug Providers (“Participating Prescription Drug Providers”) to provide prescription drug services to all persons entitled to prescription drug benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under this Health Care Plan. Under its contracts with Participating Prescription Drug Providers, the Claim Administrator may receive from these Providers discounts for prescription drugs dispensed to you.

Coinsurance amounts payable by you under this Health Care Plan will be calculated on the basis of the Provider’s Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider and the Claim Administrator for a prescription drug, whichever is lower.

To help you understand how the Claim Administrator's separate financial arrangements with Prescription Drug Providers work, please consider the following example:

- a. Assume you have a prescription dispensed and the normal, full amount of the prescription drug is \$100. How is the \$100 bill paid?
- b. You personally will have to pay the Coinsurance amount set out in this benefit booklet.
- c. However, for purposes of calculating your Coinsurance amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the \$100 prescription drug bill would be reduced by 20% to \$80 for purposes of calculating your Coinsurance amount.
- d. In our example, if your Coinsurance obligation is 25%, you personally will have to pay 25% of \$80, or \$20. You should note that your 25% Coinsurance is based upon the discounted amount of the prescription and not the full \$100 bill.

Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

2. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

- a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.
- b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.
- c. A Covered Person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

3. YOUR PROVIDER RELATIONSHIPS

- a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.
- b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.
- c. The use of an adjective such as Participating, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- d. Each Provider provides Covered Services only to you and does not deal with or provide any services to your Employer (other than as an individual Covered Person) or your Employer's ERISA Health Benefit Program.

4. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

5. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

6. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

- a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.
- b. the Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

Administered by:



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

ASO-1

Effective Date: January 1, 2011

www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and
does not assume any financial risk or obligation with respect to claims.

Exhibit E

**BJ Services Company,
U.S.A.**

**Group #18140
PPO and PPO Out- of-Area Plans
for Active Employees
Low, High & Core Options**

**Medical Benefits including
Managed Health Care and
Vision Benefits**

18140JAN.08A

Blue Cross and Blue Shield of Texas provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

January 1, 2008

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INTRODUCTION

This Benefit Booklet describes your medical benefits administered by Blue Cross and Blue Shield of Texas (“BCBSTX”), as well as your rights and responsibilities under the Medical Benefit Program. For purposes of this Benefit Booklet, all references to the “Plan” refer to the Medical Benefit Program component of the BJ Services Company, U.S.A. Welfare Benefits Program. You should call BCBSTX, the administrator for the Medical Benefit Program, if you have questions about the limits of the coverage available to you. The benefits provided under the Plan are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between the provisions of the Benefit Booklet and the official Plan documents, the official Plan documents will prevail.

The defined terms in this Benefit Booklet are capitalized and defined in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee or covered Dependents. Use of the masculine pronoun “his,” “he,” or “him” will be considered to include the feminine unless the context clearly indicates otherwise.

PPO Plan Options vs. PPO Out-of-Area Plan Options

The Plan offers two main types of Preferred Provider Organization (“PPO”) plans to all employees – the PPO Plan and the PPO Out-of-Area Plan. These two types of plans are similar in terms of the medical services each covers but differ in the way they pay benefits.

You are classified as either living inside a Plan Service Area or living outside a Plan Service Area based on your home zip code:

- If you live inside a Plan Service Area, you and your eligible dependents may participate in one of the PPO Plan options (Core, High, or Low options).
- If you live in one of the few areas where Network Providers are not available, you may participate in one of the PPO Out-of-Area Plan options (Core, High, or Low options).

If you move during the year, your classification may change. Please update your address as soon as possible after any change by contacting BJ Services Company Human Resources at 1-800-234-6487.

Network and Out-of-Network Benefits

If you live inside a Plan Service Area and participate in one of the PPO Plan options, you have the freedom to choose the Physician or Provider you prefer each time you need to receive health care services. The choices you make (e.g., to see a Network Provider or an Out-of-Network Provider) will affect the amounts you pay, as well as the level of benefits you receive and any benefit limitations that may apply.

In the PPO Out-of-Area Plan options, benefit levels for Network Providers, Out-of-Network Providers, and *ParPlan* Providers (i.e., Out-of-Network Providers that have contracted with BCBSTX) are exactly the same, and you will never be penalized if you do not visit a Network Provider. However, if you locate and visit a Network Provider or a *ParPlan* Provider, you will receive the contracted Allowable Amount (which may be lower) for the services being provided.

Managed Health Care (PPO Plan) – Network Benefits

If you are classified as living inside a Plan Service Area and participate in the PPO Plan, to receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Visit the BCBSTX website at www.bcbstx.com for the most current listing to assist you in locating a provider. The listing may change occasionally, so make sure the Providers you select are still Network Providers.

You always have the option to use Network, Out-of-Network, or *ParPlan* Providers. However, Network Providers and *ParPlan* Providers are paid according to a fee schedule negotiated with BCBSTX.

- When you use a Network Provider, the cost of services may be less than if you use an Out-of-Network Provider. As a result, when you see a Network Provider, you will receive cost savings in terms of a lower Deductible and Copayment Amount, automatic claims filing when you present your Identification Card, and for some services, a higher level of benefit coverage.
- When you use a *ParPlan* Provider, you will receive the Out-of-Network level of benefits, but will have access to automatic claims filing when you present your Identification Card and you will not be billed for services in excess of the contracted Allowable Amount.

If you participate in one of the PPO Plan options, to receive In-Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency, all care should be preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator – not you – for services provided.

The Network Provider has agreed to accept as payment in full the least of..

- The billed charges, or
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co-Share Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care (PPO Plan) – Out-of-Network Benefits

If you participate in one of the PPO Plan options and choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network (an Out-of-Network Provider), benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims to the Claims Administrator for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claims Administrator,
- Co-Share Amounts and Deductibles,
- Limited or non-covered services, and
- Failure to preauthorize penalty.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-800-521-2227	Monday – Friday 8:00 a.m. – 8:00 p.m. C.S.T.
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Preauthorization Helpline	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m. C.S.T.
Mental Health Helpline	1-800-528-7264	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health Helpline

To satisfy preauthorization requirements for Participants seeking inpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Physician, Provider of services, or a family member may call the Mental Health Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

SCHEDULE OF COVERAGE

PPO CORE PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> <i>Applies to Co-Share Stop-Loss Amounts</i>	\$2,000 – per individual \$4,000 – per family	\$5,000 – per individual \$10,000 – per family
Co-Share Stop-Loss Amounts	\$5,000 – per individual \$10,000 – per family	\$10,000 – per individual \$20,000 – per family
Maximum Lifetime Benefits per Participant	\$1,500,000	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible \$300 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit/consultation Office visit-Second Opinion Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting Independent Lab & X-ray Allergy Injections (without office visit) 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses <ul style="list-style-type: none"> Skilled Nursing Facility Home Health Care Private Duty Nursing Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days per Calendar Year	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	\$10,000 Combined Calendar Year maximum	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount after Calendar Year Deductible	

SCHEDULE OF COVERAGE

PPO CORE PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care/Serious Mental Illness Inpatient Services <ul style="list-style-type: none"> Hospital Services (facility) Physician Services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits each Calendar Year	
	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Limited to 25 visits each Calendar Year		
Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none"> Hospital services (facility) Physician services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits per lifetime	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Limited to 56 office/outpatient visits per lifetime		
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	
	80% of Allowable Amount after Calendar Year Deductible	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

PPO CORE PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care Applies to All Individuals Routine physical examinations, immunizations age 19 and over and hearing exams	100% of Allowable Amount	60% of Allowable Amount
	\$400 maximum benefit amount per individual per one-year period	
Applies to All Dependents under 19 Immunizations and routine lab & x-ray	100% of Allowable Amount	60% of Allowable Amount
Applies to All Dependents age 19 to age 25 Routine lab & x-ray	100% of Allowable Amount	60% of Allowable Amount
Applies to Employee and Spouse Only Mammography, pap smears, HPV and cervical cancer screening, PSA, routine lab & x-ray., routine colonoscopy and sigmoidoscopy	100% of Allowable Amount	60% of Allowable Amount
	Not subject to the \$400 maximum	
Speech and Hearing Services, excluding hearing aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Transplant Travel and Lodging Expenses	Limited to \$10,000 per Calendar Year	
Temporomandibular Joint Treatment Expenses <ul style="list-style-type: none"> Surgical and Diagnostic Treatment Expenses Non-Surgical Services and Appliances 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Non-surgical services and appliance limited to \$500 per lifetime	
International Prescriptions	80% of Allowable Amount after Calendar Year Deductible	

SCHEDULE OF COVERAGE
PPO CORE PLAN
VISION CARE BENEFITS

Vision Benefits	Maximum Payments
Vision Examination	60% of Allowable Amount after Calendar Year Deductible
Conventional Lenses	60% after Calendar Year Deductible
Contact Lenses	60% after Calendar Year Deductible
Eyeglass Frames	60% after Calendar Year Deductible
Calendar Year Maximum	\$400 Calendar Year maximum on all hardware and exams

SCHEDULE OF COVERAGE

PPO HIGH PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> <i>Three-month Deductible carryover applies</i>	\$700 – per individual \$1,400 – per family	\$1,300 – per individual \$2,600 – per family
Co-Share Stop-Loss Amounts	\$4,000 – per individual \$6,000 – per family	\$6,000 – per individual \$12,000 – per family
Maximum Lifetime Benefits per Participant	\$1,500,000	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible \$300 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit/consultation Office visit-Second Opinion Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting Independent Lab & X-ray Allergy Injections (without office visit) 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses <ul style="list-style-type: none"> Skilled Nursing Facility Home Health Care Private Duty Nursing Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days per Calendar Year	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	\$10,000 Combined Calendar Year maximum	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	

SCHEDULE OF COVERAGE

PPO HIGH PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care/Serious Mental Illness Inpatient Services <ul style="list-style-type: none"> Hospital Services (facility) Physician Services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits each Calendar Year	
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	Limited to 25 visits each Calendar Year	
Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none"> Hospital services (facility) Physician services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits per lifetime	
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 56 office/outpatient visits per lifetime	
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	
	80% of Allowable Amount after Calendar Year Deductible	
Accidental Injury & Emergency Care after 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE PPO HIGH PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care Applies to All Individuals Routine physical examinations, immunizations age 19 and over and hearing exams	80% of Allowable Amount	60% of Allowable Amount
	\$400 maximum benefit amount per individual per one-year period	
Applies to All Dependents under 19 Immunizations birth to age 6 Immunizations age 6 through age 18 and routine lab & x-ray	100% of Allowable Amount	60% of Allowable Amount
	80% of Allowable Amount	60% of Allowable Amount
Applies to All Dependents age 19 to age 25 Routine lab & x-ray	80% of Allowable Amount	60% of Allowable Amount
Applies to Employee and Spouse Only Mammography, pap smears, HPV and cervical cancer screening, PSA, routine lab & x-ray., routine colonoscopy and sigmoidoscopy	80% of Allowable Amount	60% of Allowable Amount
	Not subject to the \$400 maximum	
Speech and Hearing Services, excluding hearing aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Transplant Travel and Lodging Expenses	Limited to \$10,000 per Calendar Year	
Temporomandibular Joint Treatment Expenses <ul style="list-style-type: none"> Surgical and Diagnostic Treatment Expenses Non-Surgical Services and Appliances 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Non-surgical services and appliance limited to \$500 per lifetime	
International Prescriptions	80% of Allowable Amount	

SCHEDULE OF COVERAGE
PPO HIGH PLAN
VISION CARE BENEFITS

Vision Benefits	Maximum Payments
Vision Examination	60% of Allowable Amount
Conventional Lenses	60%
Contact Lenses	60%
Eyeglass Frames	60%
Calendar Year Maximum	\$400 Calendar Year maximum on all hardware and exams

SCHEDULE OF COVERAGE PPO LOW PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible Three-month Deductible carryover applies Applies to all Eligible Expenses 	\$300 – per individual \$600 – per family	\$800 – per individual \$1,600 – per family
Co-Share Stop-Loss Amounts	\$3,000 – per individual \$4,500 – per family	\$6,000 – per individual \$12,000 – per family
Copayment Amounts Required <ul style="list-style-type: none"> Physician office visit/consultation Urgent Care Center visit 	\$25 Physician office visit \$25 Urgent Care Center visit	Does Not Apply Does Not Apply
Maximum Lifetime Benefits per Participant	\$1,500,000	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible \$300 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit including lab, x-rays and office surgery Office visit-Second Opinion Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services inpatient and outpatient Independent Lab & X-ray Allergy Injections (without office visit) 	100% of Allowable Amount after \$25 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE PPO LOW PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses		
<ul style="list-style-type: none"> Skilled Nursing Facility 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days per Calendar Year	
<ul style="list-style-type: none"> Home Health Care 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	\$10,000 Combined Calendar Year maximum	
<ul style="list-style-type: none"> Private Duty Nursing 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Hospice Care 	100% of Allowable Amount	
Mental Health Care/Serious Mental Illness		
Inpatient Services		
<ul style="list-style-type: none"> Hospital Services (facility) 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Physician Services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits each Calendar Year	
Outpatient Services		
<ul style="list-style-type: none"> Physician Expenses (office setting) 	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Other Outpatient Services 	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	Limited to 25 visits each Calendar Year	
Treatment of Chemical Dependency		
Inpatient Services		
<ul style="list-style-type: none"> Hospital services (facility) 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Physician services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits per lifetime	
Outpatient Services		
<ul style="list-style-type: none"> Physician Expenses (office setting) 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 56 office/outpatient visits per lifetime	

SCHEDULE OF COVERAGE

PPO LOW PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	
Accidental Injury & Emergency Care after 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray 	100% of Allowable Amount after \$25 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care Applies to All Individuals Routine physical examinations, hearing exams and immunizations age 19 and over	100% of Allowable Amount after \$25 Copayment Amount	60% of Allowable Amount
\$400 maximum benefit amount per individual per one-year period		
Applies to All Dependents under 19 Immunizations birth to age 6	100% of Allowable Amount	60% of Allowable Amount
Immunizations age 6 through age 18 and routine lab & x-ray	100% of Allowable Amount after \$25 Copayment Amount	60% of Allowable Amount
Applies to All Dependents age 19 to age 25 Routine lab & x-ray	100% of Allowable Amount after \$25 Copayment Amount	60% of Allowable Amount
Applies to Employee and Spouse Only Mammography, pap smears, HPV and cervical cancer screening, PSA and routine lab & x-ray Routine colonoscopy and sigmoidoscopy	100% of Allowable Amount after \$25 Copayment Amount 80% of Allowable Amount	60% of Allowable Amount 60% of Allowable Amount
Not subject to the \$400 maximum		

SCHEDULE OF COVERAGE PPO LOW PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Speech and Hearing Services, excluding hearing aids <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	100% of Allowable Amount after \$25 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Chiropractic Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	100% of Allowable Amount after \$25 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	100% of Allowable Amount after \$25 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Transplant Travel and Lodging Expenses	Limited to \$10,000 per Calendar Year	
Temporomandibular Joint Treatment Expenses <ul style="list-style-type: none"> Surgical and Diagnostic Treatment Expenses Non-Surgical Services and Appliances 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Non-surgical services and appliance limited to \$500 per lifetime	
International Prescriptions	80% of Allowable Amount	

SCHEDULE OF COVERAGE
PPO LOW PLAN
VISION CARE BENEFITS

Vision Benefits	Maximum Payments
Vision Examination	60% of Allowable Amount
Conventional Lenses	60%
Contact Lenses	60%
Eyeglass Frames	60%
Calendar Year Maximum	\$400 Calendar Year maximum on all hardware and exams

SCHEDULE OF COVERAGE

PPO CORE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> <i>Applies to Co-Share Stop-Loss Amounts</i>	\$2,000 – per individual \$4,000 – per family	\$2,000 – per individual \$4,000 – per family
Co-Share Stop-Loss Amounts	\$5,000 – per individual \$10,000 – per family	\$5,000 – per individual \$10,000 – per family
Maximum Lifetime Benefits per Participant	\$1,500,000	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible \$300 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit/consultation Office visit-Second Opinion Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting Independent Lab & X-ray Allergy Injections (without office visit) 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses <ul style="list-style-type: none"> Skilled Nursing Facility Home Health Care Private Duty Nursing Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days per Calendar Year	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	\$10,000 Combined Calendar Year maximum	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount after Calendar Year Deductible	

SCHEDULE OF COVERAGE

PPO CORE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits	
Mental Health Care/Serious Mental Illness Inpatient Services <ul style="list-style-type: none">Hospital Services (facility)Physician Services	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible	
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible	
	Limited to 28 inpatient days/28 inpatient visits each Calendar Year		
	Outpatient Services <ul style="list-style-type: none">Physician Expenses (office setting)Other Outpatient Services	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
		50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Limited to 25 visits each Calendar Year			
Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none">Hospital services (facility)Physician services	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible	
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible	
	Limited to 28 inpatient days/28 inpatient visits per lifetime		
	Outpatient Services <ul style="list-style-type: none">Physician Expenses (office setting)Other Outpatient Services	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
		80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Limited to 56 office/outpatient visits per lifetime			
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none">Facility ChargesPhysician Charges	80% of Allowable Amount after Calendar Year Deductible		
	80% of Allowable Amount after Calendar Year Deductible		
	Accidental Injury & Emergency Care after 48 hours <ul style="list-style-type: none">Facility ChargesPhysician Charges	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
		80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

PPO CORE OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care Applies to All Individuals Routine physical examinations, immunizations age 19 and over and hearing exams	100% of Allowable Amount	100% of Allowable Amount
	\$400 maximum benefit amount per individual per one-year period	
Applies to All Dependents under 19 Immunizations and routine lab & x-ray	100% of Allowable Amount	100% of Allowable Amount
Applies to All Dependents age 19 to age 25 Routine lab & x-ray	100% of Allowable Amount	100% of Allowable Amount
Applies to Employee and Spouse Only Mammography, pap smears, HPV and cervical cancer screening, PSA, routine lab & x-ray, routine colonoscopy and sigmoidoscopy	100% of Allowable Amount	100% of Allowable Amount
	Not subject to the \$400 maximum	
Speech and Hearing Services, excluding hearing aids	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Transplant Travel and Lodging Expenses	Limited to \$10,000 per Calendar Year	
Temporomandibular Joint Treatment Expenses <ul style="list-style-type: none"> Surgical and Diagnostic Treatment Expenses Non-Surgical Services and Appliances 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	Non-surgical services and appliance limited to \$500 per lifetime	
International Prescriptions	80% of Allowable Amount after Calendar Year Deductible	

SCHEDULE OF COVERAGE
PPO CORE OUT-OF-AREA PLAN
VISION CARE BENEFITS

Vision Benefits	Maximum Payments
Vision Examination	60% of Allowable Amount after Calendar Year Deductible
Conventional Lenses	60% after Calendar Year Deductible
Contact Lenses	60% after Calendar Year Deductible
Eyeglass Frames	60% after Calendar Year Deductible
Calendar Year Maximum	\$400 Calendar Year maximum on all hardware and exams

SCHEDULE OF COVERAGE

PPO HIGH OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible <i>Applies to all Eligible Expenses</i> <i>Three-month Deductible carryover applies</i>	\$700 – per individual \$1,400 – per family	\$700 – per individual \$1,400 – per family
Co-Share Stop-Loss Amounts	\$4,000 – per individual \$6,000 – per family	\$4,000 – per individual \$6,000 – per family
Maximum Lifetime Benefits per Participant	\$1,500,000	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible \$300 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit/consultation Office visit-Second Opinion Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting Independent Lab & X-ray Allergy Injections (without office visit) 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses <ul style="list-style-type: none"> Skilled Nursing Facility Home Health Care Private Duty Nursing Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days per Calendar Year	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	\$10,000 Combined Calendar Year maximum	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	

SCHEDULE OF COVERAGE

PPO HIGH OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care/Serious Mental Illness Inpatient Services <ul style="list-style-type: none"> Hospital Services (facility) Physician Services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits each Calendar Year	
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	Limited to 25 visits each Calendar Year	
Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none"> Hospital services (facility) Physician services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits per lifetime	
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 56 office/outpatient visits per lifetime	
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	
	80% of Allowable Amount after Calendar Year Deductible	
Accidental Injury & Emergency Care after 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

PPO HIGH OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care Applies to All Individuals Routine physical examinations, immunizations age 19 and over and hearing exams	80% of Allowable Amount	80% of Allowable Amount
	\$400 maximum benefit amount per individual per one-year period	
Applies to All Dependents under 19 Immunizations birth to age 6 Immunizations age 6 through age 18 and routine lab & x-ray	100% of Allowable Amount 80% of Allowable Amount	80% of Allowable Amount 80% of Allowable Amount
Applies to All Dependents age 19 to age 25 Routine lab & x-ray	80% of Allowable Amount	80% of Allowable Amount
Applies to Employee and Spouse Only Mammography, pap smears, HPV and cervical cancer screening, PSA and routine lab & x-ray Routine Colonoscopy and Sigmoidoscopy	80% of Allowable Amount 80% of Allowable Amount	80% of Allowable Amount 60% of Allowable Amount
	Not subject to the \$400 maximum	
Speech and Hearing Services, excluding hearing aids	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Transplant Travel and Lodging Expenses	Limited to \$10,000 per Calendar Year	
Temporomandibular Joint Treatment Expenses <ul style="list-style-type: none"> Surgical and Diagnostic Treatment Expenses Non-Surgical Services and Appliances 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE
PPO HIGH OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
	Non-surgical services and appliance limited to \$500 per lifetime	
International Prescriptions	80% of Allowable Amount	

SCHEDULE OF COVERAGE
PPO HIGH OUT-OF-AREA PLAN
VISION CARE BENEFITS

Vision Benefits	Maximum Payments
Vision Examination	60% of Allowable Amount
Conventional Lenses	60%
Contact Lenses	60%
Eyeglass Frames	60%
Calendar Year Maximum	\$400 Calendar Year maximum on all hardware and exams

SCHEDULE OF COVERAGE

PPO LOW OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible Three-month Deductible carryover applies Applies to all Eligible Expenses 	\$300 – per individual \$600 – per family	\$300 – per individual \$600 – per family
Co-Share Stop-Loss Amounts	\$3,000 – per individual \$4,500 – per family	\$3,000 – per individual \$4,500 – per family
Maximum Lifetime Benefits per Participant	\$1,500,000	
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible \$300 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit including lab, x-rays and office surgery Office visit-Second Opinion Inpatient visits Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services inpatient and outpatient Independent Lab & X-ray Allergy Injections (without office visit) 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses <ul style="list-style-type: none"> Skilled Nursing Facility Home Health Care Private Duty Nursing Hospice Care 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	Limited to 60 days per Calendar Year	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	\$10,000 Combined Calendar Year maximum	
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	100% of Allowable Amount	

SCHEDULE OF COVERAGE

PPO LOW OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Mental Health Care/Serious Mental Illness Inpatient Services <ul style="list-style-type: none"> Hospital Services (facility) Physician Services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits each Calendar Year	
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	50% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	Limited to 25 visits each Calendar Year	
Treatment of Chemical Dependency Inpatient Services <ul style="list-style-type: none"> Hospital services (facility) Physician services 	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	60% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
	Limited to 28 inpatient days/28 inpatient visits per lifetime	
Outpatient Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	Limited to 56 office/outpatient visits per lifetime	
Emergency Care Accidental Injury & Emergency Care within first 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	
	80% of Allowable Amount after Calendar Year Deductible	
Accidental Injury & Emergency Care after 48 hours <ul style="list-style-type: none"> Facility Charges Physician Charges 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

PPO LOW OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Urgent Care Services <ul style="list-style-type: none"> Urgent Care Center visit – including Lab & x-ray 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care Applies to All Individuals Routine physical examinations, immunizations age 19 and over and hearing exams	80% of Allowable Amount	80% of Allowable Amount
	\$400 maximum benefit amount per individual per one-year period	
Applies to All Dependents under 19 Immunizations through age 18 and routine lab & x-ray	80% of Allowable Amount	80% of Allowable Amount
Applies to All Dependents age 19 to age 25 Routine lab & x-ray	80% of Allowable Amount	80% of Allowable Amount
Applies to Employee and Spouse Only Mammography, pap smears, HPV and cervical cancer screening, PSA and routine lab & x-ray Routine Colonoscopy and Sigmoidoscopy	80% of Allowable Amount 80% of Allowable Amount	80% of Allowable Amount 60% of Allowable Amount
	Not subject to the \$400 maximum	
Speech and Hearing Services, excluding hearing aids <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible
Chiropractic Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services <ul style="list-style-type: none"> Physician Expenses (office setting) Other Outpatient Services 	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible 80% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

PPO LOW OUT-OF-AREA PLAN

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Transplant Travel and Lodging Expenses	Limited to \$10,000 per Calendar Year	
Temporomandibular Joint Treatment Expenses <ul style="list-style-type: none"> Surgical and Diagnostic Treatment Expenses Non-Surgical Services and Appliances 	80% of Allowable Amount after Calendar Year Deductible	80% of Allowable Amount after Calendar Year Deductible
	Non-surgical services and appliance limited to \$500 per lifetime	
International Prescriptions	80% of Allowable Amount	

SCHEDULE OF COVERAGE
PPO LOW OUT-OF-AREA PLAN
VISION CARE BENEFITS

Vision Benefits	Maximum Payments
Vision Examination	60% of Allowable Amount
Conventional Lenses	60%
Contact Lenses	60%
Eyeglass Frames	60%
Calendar Year Maximum	\$400 Calendar Year maximum on all hardware and exams

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 19. Student Age Limit to age 25.

Dependent children are eligible for Maternity Care benefits. See the section on Maternity Care benefits in the **Special Provisions Expenses** subsection under **COVERED MEDICAL EXPENSES** for more information.

Preexisting Conditions

Preexisting Conditions are covered immediately upon a Participant's Effective Date of Coverage, with no Waiting Period.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent.

Special rules apply to determine the Eligibility Date of a new Dependent of an Employee already having coverage under the Plan. Please see the ***Dependent Enrollment Period*** section for further details.

Employee Eligibility

You are eligible for coverage under the Plan when you satisfy the definition of an Employee in the **DEFINITIONS** section of this Benefit Booklet.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Eligible Dependents generally include the following individuals, but see the **DEFINITIONS** section of this Benefit Booklet for a detailed description of Dependents:

1. Your legal spouse;
2. An unmarried child under the limiting age shown in your Schedule of Coverage;
3. A student under the limiting age shown in your Schedule of Coverage and who is attending an accredited educational institution as a full-time student (as defined by the institution);
4. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
5. Any other child included as an eligible Dependent under the Plan.

An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children. If your spouse is eligible for medical benefits under another employer's medical benefits plan, your spouse must be enrolled in his or her employer-sponsored plan to be an eligible Dependent under the Plan. If your spouse is eligible for medical benefits under another employer's group plan but does not enroll for such coverage, your spouse will be ineligible to participate in the Plan.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit an online election form or contact the BJ Services Benefit Center (866-276-2142) to make an election via telephone within the time periods described below for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your coverage elections under the Plan are timely submitted.

If you elect coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Were eligible on the Plan Effective Date and your election was made when required, your elected coverage became effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage at the levels elected shall become effective on the following Plan Anniversary Date; or
3. Become employed as an Employee after the Plan Effective Date and elect coverage within the first 30 days following your Eligibility Date, the time at which coverage initially becomes effective for you and your Eligible Dependents (i.e., your Effective Date) depends on whether you are classified by the Employer as a salaried employee or an hourly employee:
 - If you are classified as a salaried employee, coverage begins on your first day of active full-time employment as an Employee.
 - If you are classified as an hourly employee, coverage begins on the first day of the month following or coincident with the completion of one month of employment as an Employee.

If your enrollment is not completed during the periods described above and you do not otherwise waive coverage, you will automatically be assigned default coverage by the Human Resources Department. Default coverage consists of (1) family medical

coverage under the High Option at smoker rates for the PPO Plan or PPO Out-of-Area Plan, as applicable based on your home zip code, and (2) long-term disability coverage (no dental coverage or short-term disability coverage will be available). Your portion of the cost of default coverage will automatically be taken from your pay on a pre-tax basis. By accepting employment with the Employer, you expressly agree to this reduction in your pay in the event you are assigned default coverage. Once you are assigned default coverage, you cannot change those benefits until the next annual enrollment. However, if you or a Dependent experiences certain changes in family status or changes in employment status, you may change your coverage, as described in the **Changing Your Annual Election** section of this Benefit Booklet.

Coverage became effective for Employees and their eligible Dependents on the Plan Effective Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
 - c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 30 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 30 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month after you make your election.

If all conditions described above are not met, you will be considered a Late Enrollee.

Dependent Enrollment Period

1. Special Enrollment Period for Newborn Children

Coverage of a newborn child will be automatic for the first 30 days following the birth of your newborn child. For coverage to continue beyond this time, you must elect coverage within 30 days of birth and pay any required contributions within that 30-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If coverage is elected after that 30-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 30 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, you must enroll the child within the 30-day period and make any required contributions within such period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Plan Administrator after that 30-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. Qualified Medical Child Support Orders

Children who are otherwise ineligible for coverage under the Plan may become eligible Dependents if the Employer receives a court judgment, decree, or order that the Plan Administrator determines constitutes a qualified medical child support order ("QMCSO") under federal law and the terms of the Plan. A child who is the subject of a medical child support order that calls for coverage under the Plan will be enrolled in the Plan upon the determination of the Plan Administrator that the medical child

support order or notice is a QMCSO under federal law and the terms of the Plan. You or your eligible Dependents may obtain a copy of the Plan's procedure governing QMCSOs from the Claims Administrator free of charge.

4. ***Other Dependents***

You must enroll a spouse or Dependent within 30 days of the date that a spouse or child first qualifies as a Dependent. If you complete enrollment within 30 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If enrollment is not completed within the initial 30 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the application is received within 30 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

If you marry and you previously declined coverage for reasons other than under Loss of Other Health Insurance Coverage as described above, you may apply for coverage for yourself and your spouse. If the application is received within 30 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claims Administrator through the Plan Administrator.

2. If you are required to provide coverage for a child as described in ***Qualified Medical Child Support Orders*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, coverage for you will become effective coincident with the enrollment of the child who is the subject of the medical child support order.

Changing Your Annual Election

Permitted Election Changes

You should carefully consider your coverage options since your election cannot be changed until the next Open Enrollment Period unless you incur a "Change in Status," and then, only if that change is consistent with the Change in Status, except in certain situations where special enrollment rights exist. For example, if you get married, a consistent election change would be to add coverage for your new spouse as a Dependent. Except as otherwise provided in this Benefit Booklet, you generally have 30 days from and including the date you experience a Change in Status to make a corresponding change in your election by contacting the Benefits Center and completing the necessary paperwork and forms.

Generally, a "Change in Status" means:

- Legal marriage, divorce, death of a spouse, legal separation, or annulment of your marriage;
- Birth, adoption, legal guardianship, placement for adoption, or death of a Dependent (see the section on ***Special Enrollment Period for Newborn Children*** under ***Dependent Enrollment Period*** above for special rules concerning coverage for newborn children);
- A change in employment status by you, your spouse or Dependent including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence or a reduction or increase in hours of employment (including a switch between part-time and full-time status);
- Your taking of, or return from, an FMLA Leave or USERRA Leave;
- A change in your residence or worksite in accordance with the regulations under Section 125 of the Internal Revenue Code with the consequence that you become (or cease to be) eligible under the Plan;

- An event that causes your Dependent child to satisfy or to cease to satisfy the requirements for coverage due to age, student status, or similar circumstance;
- Receipt of a judgment, decree, or order that results from a divorce, legal separation, annulment, or change in legal custody that may require a change in coverage for a Dependent child, such as a QMCSO;
- Entitlement to and enrollment in (or loss of entitlement to and disenrollment in) Medicare or Medicaid by you, your spouse, or your Dependent;
- An election change made by your spouse, former spouse, or Dependent child under another employer-sponsored plan, including an annual enrollment election or a permissible Change in Status election under such plan; and
- Special enrollment rights that are triggered by a loss of health coverage by you, your spouse, or your Dependent under another group health plan or by the addition of a spouse or Dependent child, as described above under *Loss of Other Health Insurance Coverage* and *Dependent Enrollment Period*.

The Plan Administrator has the sole discretion and authority to determine whether an election change because of a Change in Status will be permitted during the Plan Year. The Plan Administrator has the right and authority to request and receive any documents necessary to substantiate a Change in Status from you.

Making Enrollment Changes

You should promptly notify the Benefits Center online at bjsbenefits.com or by phone at 1-866-276-2142 to:

- Make an election change consistent with a Change in Status event described above;
- Notify the Plan of a change to your name; or
- Notify the Plan of any change in address for yourself or your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area. If a Dependent's address and zip code are different from yours, be sure to indicate this information when you contact the Benefits Center.

Note that if you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit a *Group Enrollment Application/Change Form*, and coverage of the Dependent will become effective as described in *Dependent Enrollment Period*.

When you divorce, your child marries or reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," "Student Age Limit" or a Participant in your family dies, coverage under the Plan terminates in accordance with the Termination of Coverage provisions selected by your Employer.

Your Schedule of Coverage indicates a "Student Age Limit" for Dependent children who are full-time students on the date they reach the age limit. To continue coverage for that student up to the "Student Age Limit," submit a Student Dependent Certification Form within 60 days after the child reaches the "Dependent Child Age Limit." You may obtain this form from the Benefits Center or by calling the Claims Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Notify the Benefits Center promptly if any of these events occur. Benefits for expenses incurred after termination of coverage are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claims Administrator by the Plan Administrator, refunds will be requested.

Please refer to the **Continuation Privilege** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claims Administrator will pay for Eligible Expenses you incur under the Plan. The Claims Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with the Claims Administrator, you will be responsible for any difference between the Claims Administrator's Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles, Co-Share Amounts, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by the Claims Administrator.

Case Management

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits shall be made on a case-by-case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

Freedom of Choice

<i>Each time you need medical care, you can choose to:</i>		
See a Network Provider	See an Out-of-Network Provider	
	ParPlan Provider (refer to ParPlan , below, for more information)	Out-of-Network Provider (not a contracting Provider)
<ul style="list-style-type: none"> • You receive the higher level of benefits (In-Network Benefits) if you participate in a PPO Plan option • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • Your Provider will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive the lower level of benefits (Out-of-Network Benefits) if you participate in a PPO Plan option • You are not required to file claim forms in most cases; ParPlan Providers will usually file claims for you • You are not balance billed; ParPlan Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • In most cases, ParPlan Providers will preauthorize necessary services 	<ul style="list-style-type: none"> • You receive Out-of-Network Benefits (the lower level of benefits) if you participate in a PPO Plan option • You are required to file your own claim forms • You may be billed for charges exceeding the Claims Administrator's Allowable Amount for covered services • You must preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under the Plan. The card offers a convenient way of providing important information specific to your coverage, including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claims Administrator.
- ***Your group number.*** This is the number assigned to identify the Plan with the Claims Administrator.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claims Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining other benefits for persons not covered under the Plan;
 - d. Obtaining other benefits that are not covered under the Plan;
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator. Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co-Share Stop-Loss Amount.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claims Administrator's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Benefits and be responsible for:

- Any Deductibles,
- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claims Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will be available immediately upon a Participant's Effective Date of Coverage with no Preexisting Condition Waiting Period.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the network. When you need a specialist's care, In-Network Benefits will be available, if you are a Participant in a PPO Plan option, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, if you are a Participant in a PPO Plan option, only Out-of-Network Benefits will be available.

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

As described below, certain care and services for which benefits are available under the Plan require preauthorization. Although the decision to seek medical treatment and health care services is always up to you and your physician, the Plan will only cover care and services that are Medically Necessary as determined by the Claims Administrator whether through Network or Out-of-Network Providers and regardless of your Physician's recommendation. If a proposed treatment or stay that requires preauthorization is not appropriately submitted as explained below there may be significant limits on the benefits available under the Plan.

You should note that preauthorization only establishes in advance that care and services are Medically Necessary. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity. However, preauthorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

To satisfy preauthorization requirements, you, your Physician, Provider of services, or a family member must call one of the toll-free numbers listed on the back of your Identification Card. The call for preauthorization should be made Monday through Friday (business days only) between 7:30 a.m. and 6:00 p.m. Central time. Calls made after working hours or on weekends will be recorded and returned the next business day. A benefits management nurse will follow up with your Provider's office.

The following types of services require preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient treatment of Chemical Dependency,
- All inpatient treatment of Mental Health Care,
- All inpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In-Network Providers will preauthorize services for you, when required.

If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claims Administrator, and the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for ensuring that preauthorization requirements are satisfied. Failure to preauthorize services will be subject to guidelines described in the paragraph entitled ***Failure to Preauthorize***.

Preauthorization for Inpatient Hospital Admissions

In the case of an elective inpatient Hospital Admission, the call for preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, the call for preauthorization should be made within two working days following the admission. In the event of reasonable circumstances which prevent reporting an emergency admission within two working days, the admission should be reported as soon as reasonably possible.

Length-of Stay for Preauthorized Inpatient Admissions

When an inpatient Hospital Admission is preauthorized, a length-of-stay is assigned. If you require a longer stay than was first preauthorized, your Provider may seek an extension for the additional days. Benefits will not be

available for room and board charges for medically unnecessary days. Consistent with Federal Law, the Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- Maternity Care for the mother and newborn child in a health care facility for a minimum of
 - 48 hours following an uncomplicated vaginal delivery
 - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
 - 48 hours following a mastectomy
 - 24 hours following a lymph node dissection

Your Provider will not be required to obtain preauthorization from BCBSTX for prescribing a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer.

Preauthorization for Extended Care Expenses and Home Infusion Therapy

Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claims Administrator to request preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Claims Administrator's **Medical Preauthorization Helpline** telephone number indicated on page 2 of this Benefit Booklet or shown on your Identification Card.

If the Claims Administrator has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

All inpatient Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency should be preauthorized **before treatment begins**.

Failure to Preauthorize

If preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency as described above (or an extension of any such treatment or service), is not obtained, the Claims Administrator will review the Medical Necessity of your treatment prior to the final benefit determination. If the Claims Administrator determines the treatment or service is not Medically Necessary, benefits will be reduced or denied, as applicable. In addition, if you are a Participant in a PPO Plan option and your treatment was with an Out-of-Network Provider, you will be responsible for any failure-to-preauthorize penalty identified in the applicable Schedule of Coverage.

Review of Preauthorization Decisions

If either you or your Physician disagrees with the determination of the preauthorization, you may appeal this decision in accordance with the Plan's claims procedures described under the heading "Review of Claims Determinations" in the section **Claims Filing and Appeals Procedure**. If your appeal is made prior to or while receiving services, you may submit your appeal by contacting the Claims Administrator's Utilization Management Department at the toll-free number listed on the back of your Identification Card. In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/services has elapsed.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

This section provides information on filing a claim for benefits under the Plan.

Claim Forms

When the Claims Administrator receives notice of claim, it will furnish to you, to your Employer for delivery to you, to the Hospital, or to your Physician or Professional Other Provider the applicable claim forms for providing written evidence of a claim.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits. When you or your health care Provider (if applicable, as described below) submits a claim, it must include:

- Your name and member number as shown on your Identification Card;
- The patient's name, age, and relationship to the Employee;
- The name, address, and tax identification number of the Provider;
- The date of service;
- Bills and statements reflecting services and items furnished to the Participant and amounts charged for those services and items that are covered by the claim; and
- The correct diagnosis code(s) and procedure code(s) associated with each charge.

Who Files Claims

Providers that contract with the Claims Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

Non-Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled ***Participant-filed claims*** below for instruction on how to file your own claim forms.

Participant-filed claims

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a Subscriber-filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com